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"'HIV [...] in neon lights"

the experience of trainee and newly qualified counsellors, counselling psychologists and psychotherapists as they begin working with clients diagnosed with HIV/AIDS within the UK

Ludford, Felicity

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‘‘*HIV [...] in neon lights’’* - The Experience of Trainee and Newly Qualified Counsellors, Counselling Psychologists and Psychotherapists as they Begin Working with Clients Diagnosed with HIV/ AIDS within the UK.

by
Felicity Kate Ludford BSc

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Abstract

There is a dearth in the current literature surrounding the phenomenon experienced by psychological practitioners working therapeutically with clients living with HIV/AIDS, particularly in regards to their first encounters of this early in their careers. This qualitative piece of research attempts to illuminate what this endeavor is like for trainee and newly qualified Counsellors, Psychotherapists and Counselling Psychologists within the UK, who had chosen to undertake their required counselling placements within specialist HIV/AIDS support and counselling services. Six practitioners in various stages of their therapeutic trainings within the South of England, were recruited by purposive sampling and interviewed via means of a semi structured interview. Interpretative Phenomenological Analysis (IPA) was adopted in the exploration of the resulting transcripts, in order to allow for an in depth exploration of participant lived experiences. Four superordinate themes were identified; 'Confronting Expectations', 'Negotiating Difference', 'An Absence' and 'Transformed by the Experience' and a further eleven further subordinate themes. These themes attempt to illustrate the complex emotional journey experienced by these practitioners that appear to have had significant impact on them both personally and professionally. The discussion that follows attempt to locate these findings in the existing literature and shed light on the implications of medical advancements and changing attitudes on this work. Finally the limitations of this research were considered and the implications that this research has to the field of Counselling Psychology.

Acronyms

HIV - Human Immunodeficiency Virus

AIDS - Acquired Immune Deficiency Syndrome

PLWHA - People Living with HIV/AIDS

PWID - People Who Inject Drugs

HAART - Highly Active Antiretroviral Therapy

MSM - Men who have Sex with Men

Chapter 1: Introduction and Critical Literature Review

1.1. Introduction

This research explores the experiences of trainee and newly qualified Counsellors, Psychotherapists and Counselling Psychologists, as they begin working therapeutically for the first time with clients affected by HIV/AIDS within specific support and counselling services within the UK. In the first part of this chapter I will give an overview of HIV/AIDS, including its definition, epidemiology, history, prevalence, treatment routes and the current perspective in the UK. I will then go on to address the definition of HIV/AIDS Counselling that will be focused on in this work and will finally outline my position on this research, with my reflexivity statement. In the second part of this chapter I will go on to discuss the current research in this area and outline the rationale for undertaking this piece of work.

1.1.1. HIV/AIDS an Overview

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) are often incorrectly referred to as synonymous. HIV is a virus that attaches and infects the T-cells and CD4 cells of the human immune system, replicating itself inside of them until they are eventually destroyed thus releasing the virus further in the body. This process results in a weakened immune system, leaving the individual more susceptible to infections that previously they may have been able to fend off. The symptoms of this virus are not always immediately visible and many people report feeling no different (Stolley & Glass, 2009). However, physical symptoms of HIV can include pain, low energy, tingling or numbness in extremities (Merlin et al, 2012). Those

infected with HIV usually go on to develop AIDS, characterised by a CD4 cell count of below 200 cells/ mm3 and at least one 'opportunistic infection' such as Herpes, Pneumonia or Salmonella (CDC, 1992). The length of time that this process takes is dependent on factors such as treatment, general health and lifestyle of the individual, but usually takes eight to twelve years to develop. With the medical advances that have been made however, this gestation period has ever increased (McCord, 2008), with some people living with HIV (PLWH) never actually going on to develop AIDS (Stolley & Glass, 2009).

The first incidents of AIDS were initially identified in 1981 in California, USA, following a number of cases of homosexual men developing and quickly deteriorating from a rare cancer called Kaposi's Sarcoma (KS) and/ or Pneumocystis Carninii Pneumonia (PCP) (MMWR, 1981). Since then additional cases pre-dating this time have been identified and now, more than 32 million people have died as a result of the disease and 74.9 million infected worldwide since the start of the epidemic (UNAIDS, 2019). Epidemiologists now widely agree that HIV/AIDS originated from a mutation in a virus that affected Chimpanzees on the continent of Africa in the 1930's, which spread to humans through digestion of, or bite from the animal. HIV is now known to be transmitted through bodily fluids; blood, semen, genital secretion and breast milk, which typically result from sexual intercourse, vaginal birth, blood transfusion and intravenous drugs (Bell, McMickens & Selby, 2011). However, due to a lack of knowledge regarding transmission routes early in the pandemic, and with the impact of early media coverage, there was a great deal of fear and uncertainty at the time as to how it was transmitted. Although it is now known that HIV can be contracted by anyone, it has been seen to disproportionately affect already marginalized groups of people (Parker & Aggleton, 2003), including; men who have sex with men (MSM), at the time

becoming known as the ‘gay plague’ (Greene, 2007, p 94), sex workers, people who inject drugs (PWID) and transgender individuals (WHO, 20013b).

In response to the pandemic, Highly Active Antiretroviral Therapy (HAART) was developed and distributed in the 1990’s (Delaney, 2006), which prevents the HIV virus from replicating itself and as a result death rates from AIDS have reduced by up to 80%, (Lundgren & Mocroft, 2006). Since then, in countries where HAART is readily available, the difference between mortality rates of people infected with HIV and the general population has substantially decreased since 1981 (Bhaskaran, 2008) and found similar to that of people with other chronic health conditions such as diabetes (Zwahlen et al., 2009). With the medical advancements of the past 40 years in prevention and treatment of the disease, the landscape of care and experiences for people living with HIV/ AIDS (PLWHA), has altered dramatically. Despite continued geographical disparities in treatment, such as in developing countries (Fettig, Swaminathan, Murrill & Kaplan, 2014), HIV is now considered a manageable chronic illness as opposed to a death sentence (Hill, 2015). With some research identifying that the attitudes of PLWHA would even prefer to have HIV than Cancer or Diabetes (Mazanderani & Paparini, 2015). Furthermore, with changing representations of HIV/AIDS in the media, it has even been posed that the disease is now normalised within society or even glamorized (Scalvini, 2010).

1.1.2. UK Perspective

Although HIV/AIDS is a global phenomenon, this piece of research focuses on the practitioner experience of working with PLWHA within the UK. A report published by Public Health England

in 2016 estimated that within the UK there were 101,200 people PLWH, 13% of whom were undiagnosed (Public Health England, 2016). The populations still identified as at high risk of contracting HIV within the UK are men who have sex with men (MSM), heterosexual black African men and women, people who inject drugs (PWID), prisoners, sex workers and children who were born abroad (Public Health England, 2017). In the past ten years the number of people receiving care in the UK has increased by more than half, as a result of people living longer due to HAART treatment and the stable but high infection rates, approximately 6,000 per year (Public Health England, 2016). It can further be suggested that there is no more pertinent time to understand the experience of working with people who have HIV/AIDS within the UK, following the British Government's recent backing of plans to make HIV treatment freely available to all foreign nationals who have been living in England for more than six months. A course of action that has was taken, in part, due to the estimated 31,800 African born migrants living with HIV within the UK, 23% of whom are unaware of their diagnosis and of which almost a quarter may have acquired the disease after entering the UK (Health Protection Agency, 2012).

Although 'statistically the HIV epidemic in the UK is small, it is still a significant problem' (Rohleder, Campbell, Matthews & Petrak, 2008, p504), one which psychological practitioners are excellently equipped to work with in terms of support and prevention (Chippindale & French, 2001). With the vast psychological and psychosocial implications of a positive HIV diagnosis for people living with HIV/ AIDS and those around them, including; anxiety, depression, sexual trauma, bereavement, stigma, suicide and other mental and physical comorbidities, there will consequently be a greater number of individuals both directly and indirectly affected by HIV/ AIDS seeking psychological intervention within the UK. Within the UK there are a number of

organisations that offer holistic support to those directly and indirectly affected by HIV/AIDS such as the Terrence Higgins Trust (THT), Positive East and George House Trust. These charities offer services such as HIV testing, advocacy, financial aid, peer support, as well as counselling that is and continues to be provided by newly qualified and in training Counsellors, Psychotherapist and Counselling Psychologists.

In a survey conducted by the Terrence Higgins Trust, of 246 PLWHA over the age of 50 in the UK, it was found that 45% had experienced depression and 39% experienced issues related to anxiety (THT, 2017). Furthermore, 77% identified concerns regarding the future of their mental health, with 79% expressing concerns over cognitive impairment, loss of memory and ability to cope with their physical commodities. It was also found that 58% were living on or below the poverty line (THT, 2017). When considering this aging population, or the 'graying' of HIV/AIDS (Gorman, 2006) within the UK, along with the governments changes to Personal Independence Payments (PIP) (NAT, 2017a) and cuts in funding to specific HIV/ AIDS support services (a 28% reduction between 2015/16 and 2016/17) (NAT, 2017b), PLWHA accessing support will be facing unknown mental, social, physical, financial (Mohammadi, 2017) and employment challenges (Werth et al., 2008). It appears that both therapist and client could be faced with 'uncharted territory' (THT, 2017, p17) in the ever developing UK landscape of HIV/AIDS.

1.1.3. Reflexive Statement

Throughout this research process, I have faced surprise and curiosity from my colleagues and cohort, as to my interest in this topic area. Why had I chosen to explore this phenomenon? What

was my connection to this field? Before applying for a place on a Counselling Psychology Doctorate programme, I had identified a desire to work in the International Humanitarian Aid and Development sector, a resolve which I still have. Whilst researching this career path I established that experience in 'HIV/AIDS Counselling', as well as counselling experience in other areas such as Post Traumatic Stress Disorder (PTSD), would benefit me in this role. With this in mind I started to investigate HIV/AIDS services that I could potentially apply to for counselling placements. During this process I noticed that I felt apprehensive at the thought of undertaking work with this client group for the first time, having no prior knowledge or contact with this field. I felt this particularly so as I was coming from a place of very limited counselling experience. What would this be like? It was here that my research idea was born.

Due to logistical reasons I was ultimately unable to secure a placement within a HIV/AIDS counselling service. Although I have some regrets over this, I believe that it in part aided my attempts to bracket off my own experiences from that of the participants'. However, I also believe my lack of first-hand experience exacerbated the distance I felt between myself and the topic, as throughout the process I continued to question myself as to whether I knew enough and was able to do the research justice. Since starting this research I have however encountered a number of client groups with additional medical and health conditions, that I had no prior experience with, such as; Fibromyalgia, Myalgic Encephalomyelitis (M.E), Cancer and amputation. My experience of this was that there felt like there was something about these clients that I could never quite grasp or understand, it not being my experience. I imagined myself feeling similarly with PLWHA, not being HIV positive myself or having any personal connection, as far as I am aware

Before starting this research journey, I had not actively considered my thoughts or preconceptions about HIV/AIDS. It had not been an area I had ever considered working in or felt any connection with. On reflection, I believe this was, in part, due to it feeling as if it was not part of my narrative whilst growing up. Having been born at the end of the eighties, I had been unaware of the commotion that was taking place around me at the time. Furthermore, as a white woman, identifying as heterosexual at the time of starting this research, I admit that I felt that it was not to do with me, that there was a distance between me and 'it'. I was not part of the demographic that I thought HIV/AIDS predominantly affected. What little information I knew about HIV/AIDS prior to starting this work, I realised had come from a 'Sex and Drug Education' lesson during secondary school and from conversations with my parents, having heard them talk about their experience of being in their early twenties at the start of the HIV/AIDS pandemic in the UK. I remember my mother speaking about a huge amount of fear and uncertainty at the time, recalling watching the 'gravestone' adverts on television and the deaths of well-known celebrities, such as Freddie Mercury.

Whilst immersing myself in this research process I became aware that this fear was something that I also unconsciously held. I felt this most acutely in my role as a support worker in mental health hospital at the time, where I encountered a service user with Hepatitis C. Despite being aware of how this disease was transmitted, I noticed that I was irrationally precautious of making physical contact with this person, discreetly checking for any open cuts on myself or them, when assisting with personal care or shaking hands. I felt ignorant and ashamed disclosing this information to my lecturer and cohort during a group research discussion. Although praised for my honesty, I noticed that no one else in the room disclosed a similar experience. I wondered if it was that I was just

alone in these feelings or whether others just did not feel comfortable disclosing this. Despite this, it had felt personally and professionally important for me to share this information. However, it made me wonder; where, when and how, as trainee Counselling Psychologists, we were having these conversations about our attitudes, knowledge and beliefs about disease. As in this role, we would most certainly encounter clients affected by illness at some point in our careers (Dobbie & Mellor, 2008).

As a result of this undertaking I found myself having more conversations with friends, family and colleagues about the topic and was struck not only by the interest others had in it, but also the emotional responses it provoked, and the misconceptions that I found people held. I was grateful for this newly obtained knowledge that I had gained during the process, as I was able to educate others on the facts and it continued to serve as reminder of the power and importance that opening a narrative about sensitive or difficult topics had. As a result of this work, I have identified that I have a real interest in working with difference and have become more passionate about empowering marginalised and stigmatised communities.

1.2. Critical Literature Review

The following chapter outlines the current literature in this area that I identified as most pertinent to the focus of the research aim. It will focus initially on the mental health impact of an HIV/ AIDS diagnosis and then go on to briefly look at PLWHA's experiences of the disease and therapy. The research to date in this field has predominantly focussed on the quantitative exploration of knowledge, perceptions, attitudes and preparedness of medical and mental health practitioners,

both trainee and those with experience, towards working with this client group, of which I will illustrate. Where there has been limited research in the UK until very recently, I will draw from the current global research to help explore the research question. Due to the expanse of aspects that HIV/AIDS interrelates with, I will also attempt to shine a spotlight on the previous literature that explores the worlds of practitioners working with bereavement, stigma, sexuality, race, and ethnicity. Lastly, I will go on to solidify my rationale for this piece of work and identify its value and significance to the field of Counselling Psychology, education and training.

1.2.1. Mental Health and HIV/AIDS

Although now considered a chronic illness, HIV/AIDS appears to be perceived as different from other diseases, such as Cancer (Bravo, Edwards, Rollnick & Elwyn, 2010). It has been said that PLWHA undergo a 'unique psychological experience' (Barret, 1989, p573), including a 'social, vocational, economic, developmental and psychological impact' on those directly and indirectly affected (Ullery & Carney, 2000, p334). Despite medical advancements made in the treatment of HIV/AIDS, resulting in longer life expectancies and better quality of lives for those who are able to access it, mental health issues still continue to significantly affect those with a diagnosis (Adams, Zacharia, Masters, Coffey & Catalan, 2016). There has been extensive research on the mental health implications of a HIV/ AIDS diagnosis and the importance of psychological support alongside holistic care plan (NHS England, 2013).

Previous research has identified links between people with an HIV/ AIDS diagnosis and mental health issues, such as anxiety (Coughlin, 2012), depression, second only to substance misuse

(Rabkin, 2008), or both (Adams, Zacharia, Masters, Coffey & Catalan, 2016). It has been found that higher levels of anxiety and depression have been identified in PLWHA when directly compared to those without a diagnosis (Heckman & Carlson, 2007). This has been attributed in part to the isolation and loneliness experienced (McDowell & Serovich, 2007), levels of social support received (Fang, Chuang & Al-Raes, 2019) and internalized stigma (Lee, Kochman & Sikkema, 2002) that PLWHA often experience. It has additionally been identified that PLWHA are significantly more likely to experience symptoms of post-traumatic stress disorder (PTSD) (Beckerman & Auebach, 2010). In this study 50.2% of 166 participants who had a diagnosis of HIV/AIDS, screened positively for PTSD with higher numbers being seen in participants who identified as Transgender, Bisexual or unemployed. It has continued to be highlighted that an increasing number of individuals with HIV/AIDS would require integrated mental health support, including mental health (Remien et al., 2019) due to increased and intersecting vulnerabilities.

Furthermore, adherence to HIV medication has been found to be affected by both anxiety and depression (Willie, Overstreet, Sullivan, Sikkema & Hansen, 2016) and with links being made to higher instances of drug use (Schade, Von Groothee s & Smit, 2013). In a recent study on the comorbidities faced by 982 PLWH in and around one London borough, mental health was found to be the second highest comorbidity, in addition to physical conditions such as Hepatitis and Cardiovascular Disease (Lorenc, Ananthavarathan, Lorigan, Jowata, Brook, & Banarsee, 2014). It has also been found that PLWHA can also be affected by body image issues related to the disease, due to Lipodystrophy, the displacement of fat evident in the face of individuals receiving HAART (Kelly, Langdon & Serpell, 2009).

Increased levels of suicidality in PLWHA is particularly well documented, particularly when first diagnosed (Jia, Mehlum & Qin, 2012) and when compared to people without HIV/AIDS (Sherr., et al 2008). In this study of 778 London and Southend HIV clinic attendees, 31% were found to report suicidal ideation. Here it was identified that contributing factors included lack of status disclosure, physical and psychological impact of the disease and unemployment, with suicidal ideation reported twice as highly in heterosexual men and those of black African ethnicity, when compared to gay men and white respondents. The associated stigma that is coupled with an HIV/AIDS diagnosis also continues to be associated with high levels of suicidality (Vance, Moneyham, Fordham and Struzick, 2008). These vast and complex; physical, emotional and psychological implications that remain present for PLWHA, indicate the continued importance and relevance of mental health research in this area.

1.2.2. HIV/AIDS Stigma and Public Attitudes

Stigma has be described as the 'rejection, blame or devaluation' of a group or individual (Scrabler, 2009, p441), an othering of oneself (Goffman, 1958) from shameful or deviant aspects of the self. Although we now know that HIV/ AIDS does not differentiate between who it infects, we have seen that the diseases' impact has predominantly traversed groups of individuals already highly stigmatized, due to connection with already deeply entrenched societal taboos around sex and sexuality. As a result, negative attitudes about individuals and groups affected by HIV/AIDS and the disease itself, were rife throughout the epidemic and do still remain. However, it appears that positive progress in regards to attitudes has also been made since then.

Within the UK slight improvements appear to have been made in the general public's attitude towards HIV between 2007 and 2014. The National Aids Trust surveyed 1992 members of the British public and 79% agreed that PLWHA should receive the same care and respect as individuals diagnosed with cancer. Furthermore, 51% disagreed that individuals who had contracted HIV/AIDS through unprotected sex did not have their sympathy and lastly, 72% surveyed agreed that their relationship with a family member would not be jeopardised by a diagnosis of HIV/AIDS (National AIDS Trust, 2014). However, in a recent review of research carried out on the general public attitudes toward HIV testing within the UK, a number of barriers were identified in individuals accessing HIV testing. These included beliefs about not being at high risk of contracting the disease, concerns around being discriminated against and also regarding confidentiality of the test results (Davies & Gompels, 2015).

There also appears to still be holes in the public's rudimentary HIV knowledge such as transmission routes, such that 19% did not know that HIV can be contracted through sex between men without a condom (NAT, 2014). This research found however that there has been a rise in the public belief in incorrect transmission routes, with 16% of people questioned believing that HIV could be contracted through kissing or spitting and 5% through coughing, sneezing or sharing a glass (ibid). When 'knowledge is incomplete and patchy...it is stigma which grows in the gaps (NAT, 2014, p5). These beliefs would appear to indicate that although improvements in public attitudes continue to be made, there is still a great deal more room for this to be developed. Furthermore, it indicates that the resulting stigma is dangerous not only for those individuals already living with HIV/AIDS, but also those that are delaying testing and treatment.

Statistics regarding public attitudes and knowledge appear particularly important to focus on here, due to the early stage at which participants are in their therapeutic trainings and the limited education and focus available to them on the topic of HIV/AIDS whilst there. These beliefs may easily have been or still be held by participants at the centre of this study and impact their experience of their work with this client group, whether they feel able to acknowledge or address them is another matter.

1.2.3. The Experience of PLWHA

The question at the centre of this research regards the experience of trainee and newly qualified therapeutic practitioners currently providing intervention in the UK, for the first time to clients diagnosed with HIV/AIDS. In order to position ourselves to explore this, it seems pertinent to briefly look at the literature on PLWHA, particularly their experience of living with and the impact of a diagnosis and the experience and presentation of these issues in the counselling sessions.

As previously identified this population continues to be on the precipice of an evolving medical frontier, with individuals consequently living longer and experiencing better quality of life as well as facing new and complex challenges. Historically this disease has been shrouded in a narrative of death, hopelessness, a crisis of identity (Flowers et al., 2011) and withdrawal (Anderson et al., 2010). Themes that have been identified to arise in this work with this population being; denial, anger, rage, rejection, guilt and shame (Barret, 1989) and also the anxieties of the worried well (Winiarski, 1991). Research however has also shown that PLWHA can experience relief (Rogers & Walker, 2016) or positive and hopeful responses to a diagnosis, such as post traumatic growth

shown (Hefferon, Grealy & Mutrie, 2009) or a desire to leave a legacy (Coward & Lewis, 1993). Research has additionally identified in the experience of Gay men, a new sense of control over their lives following a diagnosis (Schwartzberg, 1993), and even a feeling of specialness. This appears similarly in a more recent UK stigma survey of PLWHA;

> *'My HIV diagnosis made me turn my life into a positive empowering experience"* Woman, 48 years old, white British ethnicity and living in the South East, diagnosed 2008' (HIV Stigma Survey UK, 2015, p 8).

There has been confusion as to the definition of HIV Counselling (Bor & Miller, 1988) and changes in the aims of HIV counselling have been identified over the years, (Balmer, 1992). However, the experience of HIV/ AIDS counselling has been found to be understood in part by clients with a positive diagnosis, as a means of: obtaining comfort and reassurance, gaining further information about the disease, using the practitioner as an intermediary with family and also as a means of negotiating the newly imposed limits on their lives (Starace, 2001). I have however, been unable to find any literature focusing on this question from the perspective of the practitioner. It has further been found that those seeking care at specialist STI services, do so in part for their perception of expert treatment (Balfe & Brugha, 2009) and reduced judgement, compared to GP services (Normansell, Drennan & Oakeshott, 2015). This presents a picture of high expectation and demand on the knowledge, skill and expertise of mental health practitioners working within this field, which I believe additionally, highlights the importance for the focus on the experience of trainees in this field.

The benefit of therapy for PLWHA has also been well documented. A recent review of research that was carried out in order to ascertain the effectiveness of psychological therapies on this population, identified improvements in client: depression, anxiety and quality of life as a result (Luenen, Garnefski, Spinhoven, Spaan, Dusseldorp & Kraaij, 2018). More specifically, the benefits of Cognitive Behavioural Therapy (CBT) (Crepaz et., 2008) and Pluralistic Therapy in this client group have also been highlighted

The answer to the question 'What distinguishes HIV/ AIDS from other chronic illnesses such as Cancer or Leukaemia?', has been proposed by (Foreman & Ní Rathaille, 2016) as 'the stigma'. Stigma has been found to affect PLWHA on numerous levels; both inside and out of the HIV/AIDS community, when having to face strong negative stereotypes and blame for the contraction route of the disease, being deemed as not the 'innocent victim' or 'damaged goods' (Sayles, Ryan, Silver, Sarkisian, & Cunningham, 2007). Furthermore there are both internal and external fears about contagion, disclosure of diagnosis to family and work (Sayles et al, 2007) and stigma associated with the associated with mental health difficulties as well as within the mental health system (Corrigan & Watson, 2002). It has been found that poor mental health has a direct negative impact on the progression of the disease (Schade et al., 2013).

In 2015 there were 88,769 people receiving specialist HIV care in the UK (NAT, 2017b). Between 2014 and 2015, of those surveyed, it was reported that 32% acknowledged still holding concerns about receiving differential treatment from their GP's due to their diagnosis and 39% from their dentist (HIV Stigma Survey UK, 2015). The experience of stigma is so powerful that in a quantitative examination of 14,203 people living in Sub Saharan Africa and Thailand, that where

there was lower prevalence of HIV and ARV coverage, there were more negative attitudes and perceived discrimination, respectively (Genberg, et al., 2009). It could be suggested then, that practitioners working with PLWHA need to be particularly careful regarding their verbal and non-verbal communication, due a suggested increased awareness and sensitivity to others behaviour that could be indicative of bias and stigma (Rintamaki, Scott, Kosenko, & Jensen, 2007). Here it was found that HIV positive healthcare service users identified; eye contact, nervousness, irritation and use of insensitive language as indicators of possible discriminatory behaviour.

1.2.4. Experience of Health Care Professionals

There has been extensive, recent and global research into the experiences of health care professionals working with HIV/AIDS of which I will briefly summarise here. This literature demonstrates the complexity and multitude of difficulties in working with this community, and that challenges are not just faced by mental health professionals in their work, but by Doctors, Nurses, Dentists and other Health Care Workers, at all stages of their training. For instance, it has previously been identified that high levels of stress and burnout are experienced by health care workers in their role with patients diagnosed with HIV/AIDS; however, there is conflicting information as to whether this is particularly associated with working with PLWHA (Miller, 1995).

Issues surrounding knowledge, confidence and attitudes have additionally been seen in a South African qualitative study on health care workers, which included nurses, advocates and adherence counsellors, it was identified that they lacked the confidence and knowledge in screening for mental health issues in patients (Mall, Sorsdahl, Swartz & Joska, 2012). In a study by (Jin,

Earnshaw, Wickersham, Kamarulzaman, Desai, John & Altice, 2014) it was also found that Malaysian medical and dental students had poorer attitudes towards patients with HIV/AIDS, MSM, PWID in comparison to other patients who were not. This can be similarly be seen in a US based piece of research where it was identified that there is a need for improvements in HIV knowledge in medical trainees (Aultman & Borges, 2006). Additionally, it was also recently identified that first generation GP's in Australia experienced a difficulty in recruiting new GP's to work with HIV in the community, although those who did work within the field did so because of how the disease was presenting now in an ageing population of patients (Newman, De Wit, Reynolds, Canavan & Kidd, 2016).

Lastly it has been found that health care professionals can also be subject to stigma and discrimination. In a study of 345 Nigerian health care workers, it was found that 80% refused surgical treatment from a doctor or nurse diagnosed with HIV/ AIDS (Sadoh, Sadoh, Fawole, Oladimeji & Sotiloye, 2009). It has been postulated that the stigma that arises from health professionals towards PLWHA has been identified as due to fear around becoming infected by practitioners (Brinsdon, Abel & Desrosiers, (2016). It appears that even now that the professionals working with this population can hold stigmatised or negative beliefs about HIV/AIDS that impact their work.

1.2.5. Knowledge, Attitudes, Perceptions & Competence

A theme that runs throughout the literature is the call for improvements in HIV and AIDS education awareness in therapeutic training (Roberts & Marshall, 2001) as it has been found that

there is a positive correlation between perceived clinical competence and past training in HIV issues (Kindermann, Matteo & Morales, 1993). To date this research has recommended the inclusion of specific HIV training in doctoral counselling psychology programmes (Elliott, Johnson, 2008), particularly focussing on students' personal prejudices and how these influence their work with this client group (Werth, 1993). In addition to the ethical and psychosocial aspects of the disease (Werth & Carney, 1994) and risk management and service availability (Ullery & Carney, 2000). At present, counselling and counselling psychology programmes in the UK offer little to no training on working with clients group (Ullery & Carney, 2000; Kukafka, Millery, Chan, LaRock & Bakken, 2009), which could result in practitioners having limited to no experience with this population before starting work with them or consequently choosing not to work with the client group at all due to lack of exposure.

It is evident that more notice has recently been paid to this subject area in recent years, with a trend for dissertation level research increasing, indicating the present felt need for research in this field. This research has looked at counsellor satisfaction with training and supervision received (Stockton, Tebasto, Morran, Yebei, Chang & Voils-Levenda, 2012), perceived effectiveness (Grinstead, & Van Der Straten, 2000), barriers and emotional consequences experienced, such as stress and workload (Peltzer & Davids, 2011). To date research in regards to psychotherapeutic work with HIV infected clients has been broad but has predominantly taken place in relation to developing countries and the US and there has been little research that investigates the gap in this knowledge within the UK. Research that has been carried out in South Africa, which has the highest rate of HIV in the world, could be suggested to only be useful and applicable to the UK to a certain point. This research suggests that the continuation into the investigation of what type of

therapeutic services and approach are suitable for people living with HIV/ AIDS in the UK is still needed. By looking at the experiences of psychological practitioners starting work with this client group in the UK, a more specific and detailed evidence base can begin to be built, so improving the quality of therapeutic services available to PLWHA within the UK and informing the Counselling Psychology profession.

Early in the pandemic it was found that trainee Psychologist perceived those with AIDS to be more responsible for and deserving of the disease, and as more dangerous when directly compared to patients with Leukaemia (Fliszar & Clopton, 1995) an indication of the stigma that was pervasive at the time, even in professionals. A further study around this time, of 185 US Clinical and Counselling Psychologists and Social workers, further revealed that they were more likely to refer patients on wards if they had a diagnosis of AIDS, when compared to a patient with Leukaemia (Crawford, Humfleet, Ribordy, Ho & Vickers, 1991). This suggested a felt uncertainty in these practitioners in how to manage this client group or a possible avoidance of the population. This could however be proposed to be reflective of the time the research was carried out, near the start of HIV/AIDS pandemic, which as previously highlighted was a period of great uncertainty and fear for people. However, it can be seen in a more recent study that referral rates for further mental health support for Black African patients, is three times lower, compared to non-Black African patients in a HIV clinic in London (Malanda, Meadows, & Catalan, 2001). This research suggested that in this instance this may have been due to the practitioners in this location, predominantly not Black African, having limited experience and knowledge of working with that population group, which may have created a barrier to exploring psychosocial difficulties with them. This research

could suggest to demonstrate the significance that time and geographical location has on research outcomes.

Previous literature in the field of HIV (Wright, 2008) has also quantitatively explored the perceptions, emotions and competencies of trainee counsellors working with PLWH, where it was identified that more fear and sadness was experienced when working with PLWH. Furthermore, the emotional impact of working with this client group was also highlighted when it was found that Counsellors identified feeling increased stress when working with PLWH who also had drug use comorbidity (Capone et al., 1992). This study went on to additionally highlight the prevalence of; a negotiation process in Counsellors, regarding the differences felt between themselves and their clients and also the importance of supervision and emotional awareness in their work. The presence of survivor's guilt in Counsellors (Kain, 1989) had questioning about how the client might feel about them not being HIV/ AIDS infected.

A recent qualitative study used Content Analysis to look at 111 US trainee counsellors perceptions of what might underlie discomfort when working therapeutically with clients diagnosed with HIV/AIDS (Richelle, Heard & Yurcisin, 2018a). From the data, six key themes were identified by participants as factors that may affect their comfort of working with this client group; knowledge, fear, HIV stigma, personal experience and beliefs and sex/ sexuality. Fear in this study was identified as predominantly around visible symptoms of the disease. It has also been identified that both therapists and client may experience anxiety and an avoidance of the 'dreaded issue', such as the topic of pain, disfigurement, uncertainty and loss (Bor & Miller, 1988, p399). These researchers additionally looked at student counsellors perceptions of the challenges they might

face when working therapeutically with families, where a member has HIV/AIDS (Richelle, Heard & Yurcisin, 2018b). From this research five themes emerged. Participants identified a perception, both in themselves and their clients, with issues surrounding: knowledge and beliefs, HIV stigma, grief, empathy, and resources and support. Again knowledge, or lack of it, was identified as a primary factor in their discomfort. In (Richelle, Heard & Yurcisin, 2018a) study however identified that its results were limited in the fact that participants may have not actually started working with this client group. They concluded that there was further value in accessing Counsellors insight into working with this client group, for its implications for professional development. It is here that I locate the current investigation and its potential to contribute to the knowledge base and further understanding of this work.

Parallels have been drawn between the competencies required in counselling clients both with and without HIV/AIDS. However, due to the complexities and impact of a positive diagnosis, additional competencies in stress, anger, grief and loss work have been identified as beneficial for Counsellors working with this client group (Werth & Carney, 1996). This research further identified that trainee counsellors also require a strong foundation in HIV knowledge, concerning the terminology, transmission, treatments and the landscape of the disease as well as an increased awareness of risk and ability to work imaginatively (Gurnney,1995) being needed.

A quantitative study on the knowledge, beliefs and social comfort of US trainee counsellors working in schools, with young people directly and indirectly affected by HIV/ AIDS, identified a relationship between lower levels of HIV knowledge in the trainee counsellors and lower levels of social comfort and also increased negative beliefs (Carney & Cobia, 2003). These trainee

counsellors felt preparedness to work with this client group was found to be related to their levels of knowledge on the area. Only 29% of participants felt fully prepared to work with this client group as a result of their level of knowledge and counselling skill. This study went on to identify numerous concerns held by counsellors working with this client group. Almost half (43%) of the 97 participants here, expressed worry about working with clients facing their own mortality, and anxiety around how they would manage the emotions (Carney & Cobia, 2003, p 309). One qualified practitioners reflection on his work with PLWHA in the eighties identified a moving, loneliness, an experience of facing your own fears (Barret, 1989) and demanding, rewarding experience (Winiarski, 1991).

The knowledge and attitudes, of 30 rehabilitation counsellors who work with clients with HIV/AIDS diagnosis, in addition to a substance dependency and/ or dual diagnosis was explored (Alston, Wilkins & Holbert, 2007). In this US based, mixed methods piece of research, the counsellors were mostly found to have tolerant attitudes towards HIV/ AIDS. Furthermore, these rehabilitation counsellors were found to frequently draw comparisons in the difficulties they faced in their work with these clients to that of clients with cancer or diabetes. The societal stigma faced by these clients was often present in the work. It was however found in (Fliszar & Clopton, 1995) that when compared to earlier studies (Crawford et al., 1991), a positive shift in attitudes towards patients with AIDS was demonstrated by trainee Psychologist, highlighting a need to have an up to date reflection of trainee Counsellors experiences in this field as changes occur.

A quantitative study of 120 US mental health counsellors working in private and public practice identified that 70%, had worked with this client group (Ullery & Carney, 2000). Here it was found,

using the AIDS Attitude Scale (AAS) (Shrum, Turner & Bruce, 1989) and HIV/AIDS Knowledge Inventory (HAKI) (Carney, Werth & Emanuelson, 1994) were used to measure attitudes and general knowledge of PLWHA, of these practitioners. The research found that these practitioners had good general knowledge about the disease which was received outside of their university and that their attitudes did not relate to training received. Participants with personal relationships with this client group had higher knowledge and better attitudes. This research highlighted the importance of not just knowledge but also attitude and awareness, suggesting further that exploration in this area is needed, particularly into how mental health practitioners prepare for their role with this client group. This research further highlighted significance of mental health Counsellors' motivation to seek training. It was found that Psychologists in the US learned about HIV on their own through the media, not through formal training at university (Schmeller-Berger et al., 1998). In (Rose et al., 2015) they attempted to gauge current levels of HIV/AIDS knowledge in 70 trainee and qualified counsellors in one US state. This quantitative piece of research utilised the condensed HIV Knowledge Questionnaire (HIV-KQ-18) (Carey & Schroder, 2002) and additional questions relating to transmission, treatment and symptom knowledge of the disease, were used to assess this. It was identified that these counsellors had some knowledge on HIV/AIDS, but not much more than the general public and that older counsellors had less knowledge.

Research has also been conducted to examine the stigma experienced by those who volunteer to work with people living with HIV/ AIDS (Omoto et al., 1998a). Experience, expectation and the affect their volunteering had on their lives, were compared between those offering emotional and practical support to people with HIV/AIDS and people with other 'serious illness'. Here it was

found that those that volunteered to work with PLWA both expected and experienced more stigma, and were also found to be more stressed and demoralised than their counterparts. A cluster of studies on potential volunteers at a US college, indicated a decreased willingness to work with people diagnosed with AIDS when compared to cancer, with prejudice and illness-related fear identified as potential barriers to this work and the stigma they might experience from their friends and families (Omoto, Snyder & Crain, 1998b). It has been suggested that this perceived potential for stigma is a result of "courtesy stigma" (Goffman, 1963, p32), or stigma by association (Snyder, Omoto & Crain, 1999).

1.2.6. Practitioner Comfort with Death and Sexuality

HIV/AIDS touches many taboo subjects; sexuality, death and disability (Kiemle, 1994). It has been documented that trainees tend to avoid discussing death in session and that scenarios related to AIDS, terminal and bereavement and suicide, are found more distressing than others (Kirchberg & Neimeyer, 1991). It was also identified by (Nord, 1996) that Counsellors may feel overwhelmed by the multiple AIDS related losses their clients may have experienced, if they have limited prior experience with this topic. This research however was located at a different time, where death from the disease would have been more prevalent. A study of 58 Masters level trainee counsellors found that discomfort levels were significantly higher in response to vignettes depicting scenarios related to death and dying, particular those related to terminal illness and suicide (Robert, Richard & James, 1998). This research highlighted the importance of trainee awareness around their own difficulties with death and dying. Further issues surrounding Counsellors fear of contagion that may arise in a change in behaviour around client have been identified (McKusick, 1988).

Research has additionally been carried out to explore the experiences of trainees encountering challenging situations in their therapeutic client work. In a qualitative exploration of twelve trainee Counsellors encountering non-suicidal self-injury for the first time it was identified that both professional and personal difficulties in regards to their own emotion regulation, and awareness of unconscious communication made their work more difficult; moreover, their supervision only partly helped to support them (De Stefano, Atkins, Noble & Heath, 2012). It has been identified that working directly with clients identified as having the most significant impact on learning and development (Orlinksy, Botermans & Ronnestad, 2001).

Sex and sexuality can also be seen to pervade many aspects of life and so therapeutic work (Diambra, Pollard, Gamble & Banks, 2016),but particularly with this population. Despite positive trends in LGBT education, Counselling graduate students have reported feeling unprepared to deal with LGBT clients and credit part of this to not receiving adequate course work in the area (Phillips & Fischer,1998; Phillips, 2000). Furthermore previous literature has identified that many therapists are unprepared to deal with sexuality in general, but especially with gay and lesbian issues (Murphy, 1991) and furthermore in providing effective counselling to sexual minorities in (Bahr, Brish & Croteau, 2000). Trainee Psychologists demonstrate a bias towards gay and lesbian men when breaking confidentiality around risk (Palma & Iannelli, 2002) and link between Counsellor homophobia and empathy and willingness to accept the client for therapy. (Hayes & Erkis, 2000).

In (Harris & Hays, 2008) it was found that therapists education and supervision on issues such as sexuality; best predicted these topics being approached by the therapist in the session, increased

therapist comfort with discussing these issues and also improved confidence and knowledge on the subject. It was also found in a study of sexual health knowledge and attitudes practitioners of practitioners at a US youth mental health agency (Russell, 2012), that included Counsellors and art therapists, that knowledge decreased barriers to discussion with patient. Research has also been conducted too that shows improvements in Counsellor attitude towards gay men and women following a 3 day workshop (Rudolph, 1989). An avoidance of discussing sexual issues has also been found in Psychiatric settings (Collins, 2006). This phenomenon is however not just located in the mental health field, in a qualitative study of 22 UK GP's it was identified that patient sexuality was viewed as a potential barrier between themselves and their patients'. This was found specifically in regards to GP's feelings that they lacked enough knowledge about LGBTQ sexual health and the correct language to use and a possible reluctance to work in this field. These GP's identified that more training in this area would be beneficial to them and their patient's experience (Hinchliff, Gott & Galena, 2005). From this literature, it could be suggested that the participants of this study may express a difficulty in, avoidance of, or discomfort in discussions of a sexual nature.

1.2.7. Relevance to Counselling Psychology and Rationale for the Study

As previously highlighted, the global and UK landscape of HIV/AIDS has evolved a great deal since the initial pandemic and due to medical advancements and changing attitudes, PLWHA are living longer and better quality lives. However, they are also facing new and unknown challenges. With the complexities of the physical, mental, emotional and financial difficulties that can arise with the disease, this population appears very likely to access mental health support at some stage

in their life. It appears however that although very likely, HIV/AIDS in the current literature and therapeutic trainings in the UK is lacking.

I suggest that this raises an important and relevant question of what is this experience like then, to begin working in this field as a trainee or newly qualified therapist in the current climate, potentially having had no contact with the group before. It has been identified that 'Counselors can no longer contemplate if they will have clients infected, affected, or at-risk for HIV/AIDS, but rather when they will counsel such persons.' (Rose et al., 2015, p7).The importance of the continued and further contribution that Psychologists can make to the field (Rohleder, Campbell, Matthews & Petrak, 2008) and the importance of a 'holistic and developmental perspective' in the treatment of HIV has been highlighted (Rose et al., 2015), an approach synonymous with Counselling Psychology. It can be suggested that Counselling Psychologists are uniquely positioned to evolve with the changing landscape of this disease and attend to the multicultural dimensions (Goodyear et al., 2000). It was (Rose et al., 2015) who called for thorough continuous training, the provision of more than basic knowledge, but also training specifically to working therapeutically with this client group such as legal and ethical issues and their comfort in working with PLWHA.

The aim of this research is to explore in depth the experiences of trainee and newly qualified Counsellors, Counselling Psychologists and Psychotherapists as they begin working therapeutically for the first time with clients diagnosed with HIV or AIDS within the UK. To my knowledge there has been little to no research conducted that explores this phenomenon. It became apparent during my search of the literature that relatively little recent research had been conducted

in this area at all and what was available was predominantly a quantitative endeavour, focussed on the measurement of practitioner knowledge, attitudes, comfort and perception of this work, not specific to the UK. I did identify a small number of more recent studies, which I believe reflect a resurgence of interest and importance in this area that is attempting to build upon historic knowledge, bridging the gap between then and now. We do not know what this endeavour is like for trainee and newly qualified Counselling Psychologists or psychological practitioners, however, from the available literature, an experience that is emotionally challenging, complex and rewarding could be anticipated.

Chapter 2: Methodology and Procedures

2.1. Methodology

This chapter will begin with an outline of my epistemological position and will then go on to present my rationale for utilising a qualitative methodology, specifically Interpretative Phenomenological Analysis (IPA), whilst demonstrating my consideration of possible alternatives. It will then give an overview of the theoretical and philosophical underpinnings of IPA and place it within the context of Counselling Psychology.

2.1.1. Qualitative Paradigm

Research in the field of psychology and the social sciences has historically had a firm grounding in the positivist epistemology (McLeod, 2003) and its search for one objective truth that can be known (Willig, 2001). Whereas quantitative research is defined by the 'measurement and analysis of variables, using tests, rating scales and questionnaires' (Barkham, 2003, p25), qualitative research has been defined as 'the collection and analysis of the accounts or stories that people offer regarding their experience' (McLeod, 2003, p75). In recent years there has been increased popularity in the use of qualitative methodologies, particularly in the field of Counselling Psychology (Morrow, 2007). This is in part due to its ability to access richer, more in depth detail on an individual's experience and understanding of their perspective (Elliott, 1995). Qualitative approaches that can be utilised, include; Grounded Theory, Discourse Analysis, Thematic Analysis and Narrative Analysis about which I will provide further detail later in this chapter.

2.1.2. Rationale for Approach

The decision to utilise a qualitative methodology was informed by a number of factors. This research initially evolved from a desire to conduct a quantitative study, measuring Counsellors' perceptions and willingness to work with PLWHA, before and after training on the topic area. Having completed an undergraduate degree in psychology in the UK, my knowledge, confidence and research experience was rooted in the quantitative paradigm (Ponterotto, 2005). However, as a result of my training as a Counselling Psychologist and experience of hearing clients' life stories during therapeutic practice, I developed a deeper interest and respect for qualitative exploration, my eyes opened to other more creative possibilities. This increased methodological awareness, in conjunction with further immersion into the literature in this field, resulted in a natural evolution of the research question and so the methodological direction. The new research question aimed to shed light on the experience of trainee and newly qualified counsellors, working for the first time with clients with a HIV/AIDS diagnosis. Examining how they describe and make sense of this endeavour and trying to answer the question; 'What is this like?' A question (Creswell, 1998) claimed was best suited to be answered by a qualitative methodology and particularly IPA (Smith, Flowers & Larkin, 2009).

As a result of the review of the existing literature in this field it is evident that it has been dominated by quantitative studies (Roberts & Marshall, 2001; Carney & Cobia, 2003; Wright, 2008). Furthermore, to my knowledge there is no research at all that has examined the phenomenon at the focus of this current piece of work, which Howitt & Cramer (2008) identified as a prerequisite for

the utilisation of a qualitative methodology. Due to the ever evolving complexity of the disease: socially, politically, historically as well as the stigma that surrounds it, the subject area can be nuanced and difficult to discuss. It can be suggested that the opportunity for practitioners to explore their experience in depth for this research, would be of great value to the field. It was Marrow (2007) who identified that a qualitative methodology was useful in addressing and fortifying areas of research that have limited to no literature available, or when previously only looked at from a quantitative perspective (Smith, 1996) and furthermore seen as complementary tool to quantitative research (Cresswell, 1998). It was also whilst immersing myself in the literature that my interest in the subject area grew along with my commitment to improving the knowledge base of the phenomenon under study, an aspect of qualitative research and researcher that (Smith et al, 1999) distinguished as important.

A number of other qualitative methodologies were considered in the process of planning this research including; Thematic Analysis, Conversation Analysis, Discourse Analysis, Narrative Analysis and particularly Grounded Theory. The use of Interpretative Phenomenological Analysis (IPA) appeared particularly appropriate, primarily due to the fact that its methodological paradigms aligned with my epistemological viewpoint, that knowledge and meaning is co constructed. As a qualitative researchers I do not claim to generate 'universal' truths or scientific laws but rather strive to build meaningful 'local knowledges' (McLeod, 2003, p75). Unlike Thematic Analyses, Discourse Analyses and Grounded theory that make generalisations about the wider population, IPA remains focused on the experience of the individual or the few (McLeod, 2011), paying particular focus to the divergent and convergent elements between participant experience (Smith, Flowers & Larkin, 2009).

The use of IPA was further deemed appropriate due to its established use in the exploration of disease and health psychology and its capacity to access that which cannot readily be seen. It also felt furthermore fitting, as parallels have also been drawn between the significance of the collaborative interaction that take place, between participant and researcher, and client and practitioner, in research where there is a qualitative methodology (Yardley, 2000). This could be suggested as particularly identifiable within an IPA's hermeneutic endevour, which attempts to bracket off prior assumptions or pre-existing knowledge frameworks much as you would do in a therapeutic.

2.1.4. IPA: Theoretical and Philosophical Underpinnings

Interpretative Phenomenological Analysis (IPA) was first presented in (Smith, 1996) as an alternative qualitative research approach to the field of health psychology. Since this time the use of IPA has continued to grow in popularity within the field of Psychological research, with (Ponterotto, 2005) identifying a shift from the quantitative to the qualitative. It has been suggested that its popularity is due to its 'accessibility, flexibility and applicability' (Larkin, Watts & Cliffton, 2006, p 102), but also due to the fact that the methodology is based within the field of Psychology, and not another domain (Smith et al, 2009). IPA is identified as more than just a 'descriptive methodology' (Larkin, Watts & Cliffton, 2006, p 102), but rather a stance or approach to undertaking the research, here the researcher is part of the research (Smith, 2015). The use of this methodology enables a detailed, in depth exploration of the understanding and meaning making of an individual's experience of a phenomenon. Although it has been argued that IPA lacks theoretical

rigour (Shinebourne, 2011), it in fact draw up on three core philosophical elements; Phenomenology, Hermeneutics and Idiography.

2.1.4.1. Phenomenology

The first theoretical assumption of IPA is that of Phenomenology. Edmund Husserl philosophical stance of Phenomenology, regards the interest in the individual's experience of object or event, particularly something important of meaningful, and how it is made sense of, talked about and understood by them. Put simply it is the exploration of what it is to be human (Smith et al, 2009). Phenomenology is concerned with the identification and exploration of the essentialness of these experiences (Pietkiewicz & Smith, 2012), what distinguishes these moments as different from all others. This approach is free from the boundaries of the 'natural attitude' (Smith et al, 2009) of reducing and categorising into already established perceptions and means of categorising. This can in part be achieved through the process of 'bracketing off', to attempt to compartmentalise, although not disappear, that which is already known to us and our way of understanding the particular phenomena under study. Husserl proposed that in part this bracketing could be achieved through techniques of 'eidetic reduction' which seek to uncover different perspectives for discovering the phenomenon, such as free association (Smith et al, 2009).

2.1.4.2. Hermeneutics

The second theoretical assumption of IPA is that of Hermeneutics, the 'theory of interpretation' (Smith et al, 2009), developed from Edmund Husserl's ideas by a supporter of his work, Martin

Heidegger. This theory informs IPA in its quest to know whether an individual's experience can ever truly be known or understood by another. It proposes that any attempt to understand another's world experience, by attempting to stand in their shoes (Pietkiewicz & Smith, 2012), can only ever really be an interpretation from the viewers perspective through a double hermeneutic process, as the others experience is not directly accessible, a double hermeneutic.

2.1.4.3. Idiography

The last theoretical tenet of IPA is Idiography, an approach that is 'concerned with the particular' (Smith et al, 2009, p29). The idiographic nature of IPA is apparent in its detailed and in-depth analysis of particular people's experience of particular phenomena. As a result small homogeneous samples, including individual case studies (Smith, 2004) are specifically located and selected. Whereas quantitative research methodologies pose to make more general claims about their results to the wider population, a 'nomothetic' approach, IPA is focused on the detailed understanding of how a specific population made sense of a specific phenomenon (Smith et al, 2009).

2.2. Procedures

The second part of this chapter will detail the ethical considerations and procedural aspects of the research and will discuss the process of assessing for quality and validity.

2.2.1. Ethical Considerations

In accordance with the British Psychological Society's (BPS) Code of Ethics and Conduct (2009) this research was submitted for ethical consideration under the reference PSYC 14/ 150 in the Department of Psychology and was initially approved under the procedures of the University of Roehampton's Ethics Committee on 18.12.14 (Appendix A). The ethical issues that were considered during the procedural process will be detailed below.

2.2.1.1 Informed Consent

Once participants had voluntarily made contact with me expressing interest in participating in the research, they were emailed a copy of the participant consent form (Appendix D) and demographic questionnaire (Appendix E) to sign. The consent form outlined the study and what participation entailed. Participants were also informed that they were free to withdraw without any reason at any point during the research. They were also made aware of this fact at various stages throughout the research process. The consent form also advised them that if they were to withdraw, their data may still be used in an aggregate form. Additionally this form made participants aware that their interview data would be stored and held securely for a period of ten years after which point it would be destroyed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

Participants were also asked whether they wanted to receive a copy of the interview transcript made from the audio recording, so that they could make any amendments they wanted. Of those asked, two participants requested a copy. One of these participants responded and agreed for it to be used, the other did not reply so their data was removed from the project. Following discussion

with my supervisors and the ethics committee, it was decided that participants whose data was not included in the final analysis, as will be discussed in the next section, were not informed of this decision. Although their data was not included in the final study, their interviews were vital in the shaping of the research and I am immensely grateful for their participation.

2.2.1.2. Anonymity and Confidentiality

Participant data was made anonymous through use of numbers and pseudonyms that in no way related to their real name and all identifying information was removed, which has been detailed further in Chapter Three. To ensure confidentiality, participant consent forms, transcripts and audio recordings were kept separate from each other and stored in a secure filing cabinet, a password protected laptop and external hard drive. Following transfer of the original recording onto my laptop, these files were deleted from the audio recorder. The consent form also made it clear to participants that their data would be treated as confidential unless the information shared suggested that there was a serious risk of harm to self or others. These forms were also read through with the participant at the beginning of the interview in order to verify informed consent and empower participants.

2.2.1.3. Participant Distress

As previously highlighted the subject of HIV/AIDS traverses a number of complex and distressing topics, such as illness, death, sex and sexuality. As a result, I was conscious of the potential for the questions asked of participants during interview to result in unexpected and unwanted feelings of

discomfort or distress. Or for the possibility of these trainee and newly qualified psychological practitioners to feel forced to confront aspect of their personal and professional selves that they were not prepared for or did not want to see. Similar to my own feelings of shame and isolation when sharing my fears surrounding work with illness, particularly if mot reciprocated or reassured by others.

In consideration of these potentialities, interviews were arranged in locations that were most convenient, comfortable and familiar to participants, such as their homes or at their clinical counselling placements. Participants were also advised that during the interview that they were able to stop the process at any time or take regular breaks. Additionally, in order to reduce this risk of distress, participants who had had experienced a death related to HIV/AIDS in the last two years, were not selected for interview. During the interviews I was mindful of any distressing topics that arose, however no participants became upset during their course. Following the interview, participants were given a debrief form (Appendix F) which provided them with contact details for support services such as the Samaritans if they became distressed at a later date as a result of the interview and needed emotional support. They were additionally given the contact details of the supervisory team should they subsequently have any concerns.

2.2.1.4. Researcher Safety

In accordance with the University of Roehampton's 'Lone Worker Policy' when going on my own to meet a participants for interview, such as in their homes, university campuses or counselling placements, I made sure that another person was aware of the location and timing of the interview,

in order to ensure my safety. I also ensured that my mobile was charged and working and it was agreed that if I did not call the named person by the time the interview was meant to have been completed, they would call me or raise the alarm. All communication took place over university emails.

2.2.2. Participants and Sampling

Due to the time consuming and labour intensive nature of IPA, (Smith et al, 2009) I proposed that in order to allow for a thorough and in depth analysis of the considered phenomenon, between four and ten participants were appropriate for Doctoral level research. The final sample of six participants included: five women and one man aged between 27 and 59 years.

2.2.3. Inclusion Criteria

The initial conception of this research had been to explore the experience of qualified Counsellors and Counselling Psychologists, with no formal training in HIV/AIDS, who had encountered PLWHA in their therapeutic work during their career within the UK. Following recruitment, interview and preliminary analysis of four participants, I discovered that the inclusion criterion was still too broad. Participants' experiences spanned a broad period of time, ranging from very recent but up to 15 years ago. Furthermore, participants had encountered this client work in a variety of settings. Following discussion with my supervisors and reflection on the current literature, a decision was made to tighten the inclusion criteria further in order to direct the research towards a sample as homogenous as practically possible, more in keeping with the idiographic

nature of IPA and (Smith et al, 2009). Below I have detailed the inclusion criteria for the final sample, as agreed by Roehampton Ethics Committee following amendments:

- Participants had to be over the age of 18.
- Participants were English speaking.
- Participants were not to have experienced a death related to HIV/AIDS in the last two years in order to minimise or avoid emotional distress.
- Participants had to either be currently in training in the UK as a Counsellor, Psychotherapist or Counselling Psychologist or have recently qualified (within the last two years). This time frame was set in order to aid participant recall of the experience of starting work for the first time within this field, to get as close to the phenomena as possible (Schmolck, Buffalo & Squire, 2016).
- Participants had to have started working therapeutically for the first time with at least one client with a diagnosis of HIV/AIDS, during this time.
- Participants were not to have any previous experience working therapeutically with clients directly or indirectly affected by HIV/AIDS.
- The therapeutic work had to have been carried out in an HIV/AIDS specific support and counselling service within the UK. This decision was made so that all participants would have chosen to work in this field and be expecting to undertake therapeutic work with this client group, in order to keep the sample as homogeneous as possible.
- All participants were included regardless of gender, race or sexuality. It is possible, that for example, a homosexual man might experience this work differently to that of a

heterosexual woman. Following discussion with my supervisor, I did not limit my sample in this way due to the already specific nature of the phenomenological enquiry.

- It was decided not to ask whether participants had a diagnosis of HIV/AIDS themselves due to the personal nature of this disclosure.

Additional demographic information was collected including before the interview, such as; theoretical orientation of the Counsellor and the professional body they were registered with. Participants were also asked whether they had received any formal training on HIV/AIDS prior to working with this client group. In the original inception of this research, participants who had received training in the area were to be excluded from the sample in order to increase homogeneity in the recruited participants. However, due to the specific nature of the research question and population sample, it was considered appropriate to instead just enquire whether they had received training in this area. This would also allow for this to inform any convergence and divergences interpreted in the data collected, in the Discussion chapter.

Below is table (Table 1.) illustrating the demographic information gathered at the start of the interview process.

Table 1. Participant Demographics

Pseudonym	Age	Gender	Ethnicity	Sexuality	Theoretical Orientation	Professional Body	Year of Training	HIV Training?
Margaret (006)	-	F	-	Hetero - Sexual	Integrative	UKCP	4th	No

Jonathan (007)	32	M	Greek	Homo - Sexual	Integrative	UKCP	3rd	No
Naomi (008)	59	F	Black/ American	Hetero - Sexual	Integrative/ Transpersonal	Student BACP/ UKCP	Final Year	No
Angela (010)	49	F	White/ British	Hetero - Sexual	Integrative/ Transpersonal	Student UKCP	5th	No
Rachel (011)	27	F	White/ British	Hetero - Sexual	Person Centered/ CBT	Student BPS	2nd	No
Grace (012)	29	F	White/ British	Hetero - Sexual	Integrative	Student BACP	1st	No

2.2.4. Recruitment Process

In the initial recruitment process, participants were recruited through purposive sampling. The Counselling Directory website (www.counselling-directory.org.uk) was used in order to search for and contact participants who were advertised as having had experience working with HIV/AIDS. Recruitment emails and posters were also sent to general counselling and support services in the UK. Following the alterations made to the focus of the research, I went on to recruit seven participants who met the updated inclusion criteria. Participants were recruited through purposive and snowball sampling. Participants were recruited through various methods as outlined below:

- Recruitment emails (Appendix B), which included a recruitment poster (Appendix C) which they were asked to display or distribute, were sent to;

    - HIV/AIDS specific organisations and charities that offer support and counselling services within the UK.
    - General counselling and support services in the UK.
    - Counselling, Psychotherapy and Counselling Psychology university and college programmes within the UK.
- A recruitment poster was also submitted to the;
    - BPS monthly news bulletin.
    - BPS and Division of Counselling Psychology (DCop) Facebook groups.
- With their permission, I also approached people who had been suggested by other participants in this research.
- I was also approached by participants who had been directed towards the research by participants who had already taken part in the research. and recommended towards

From this recruitment process, seven participants were identified and interviewed. Following interview one participant did not respond to the transcript feedback request email, so that participant's data was not included in the final piece of research.

2.2.5. Interview Schedule and Procedure

The interview schedule (Appendix G) included seven core questions, listed below which were constructed following consultation with the current literature on this area, discussion with colleagues and supervisors and pilot interviews. These open-ended questions were not strictly adhered to, but rather used as a guide. However, I found that with all of the interviews, many of

the questions were naturally addressed by the participant in the flow of the conversation, without the question being asked directly. Prompts such as ‘Could you tell me more about that?’, ‘How did that make you feel?’ and ‘What was that like for you?’ were used to help deepen the level of inquiry.

1. What prompted you to undertake a placement/ start working within this organisation/ charity?

2. What was your knowledge and experience of HIV/AIDS prior to starting work with this client group (if at all)?

3. Could you tell me about any expectations you had going into the work (if at all)?

4. Can you remember your first (then next) experience of working therapeutically with this client group - could you tell me about that experience?

5. What impact, did their HIV/AIDS diagnosis have on you (if any)?

6. Were there any particular challenges/ difficulties you faced during the work (if any) and how did you manage them?

7. Did you notice any changes in the way you felt as the work progressed?

A semi structured interview style was used in order to carry out the face to face interviews with participants. At the beginning of all the interviews participants were informed that I was going to ask them a few questions and were reminded that there was no right or wrong answer. I emphasised that I was very interested in hearing what their experience was like, starting to work therapeutically with this client group for the first time. I also asked permission from participants to write down notes as we spoke in order to aid me in remembering points to come back to. This was done in order to socialise participants about what to expect from the interview (Smith et al., 2009).

To allow enough time to cover the interview schedule in a timely manner and for any further routes to be explored if and when they arose, participants were informed at recruitment to allow for approximately 60-90 minutes for the interview. This time frame also allowed time for me to ask participants introductory questions, such as 'What had made them come forward to participate in this research?' and to ask general questions about the nature of the counselling placement. The aim of this was to facilitate a rapport between myself and the participant and to help them feel more comfortable with the interview process as a whole. Interviews had also been organised at times and in locations that were most convenient for participants in order to aid this. Two of the interviews were carried out at the participant's university, two in participants counselling placements and two in participant homes. I was also mindful of the power difference between myself, as researcher, and the participant. In order to minimise this, I attempted to remain open to participants comments about the research (Bravo-Moreno, 2003).

I found that they were very open to discussing their experiences, glad of the opportunity to think about what their experience had been like for them. A number of participants highlighted the fact that they had had not previously had space to do so and appreciated the opportunity to reflect on their work. Following each interview, I used my process journal to write down my thoughts so that I could refer to them. I found myself excited and curious about the accounts that participants had given and unexpectedly protective, feeling privileged to share those experiences with them. There were moments that had felt uncomfortable and out of my depth, but with each interview I found myself gaining more confidence as an interviewer.

2.2.6. Data Analysis

Following each participant interview the audio recordings were transcribed verbatim, as soon as was possible, in order to facilitate as accurate memory of the events (Hollway & Jefferson, 2005). This practice was also advised by a lecturer, in order to keep on top of the work. In (Smith et al, 2009) it is proposed that unlike Conversation Analysis (CA), when utilising IPA, nances in talk such as the length of the pause taken by participants is unnecessary to be transcribed. However, any significant speech should be noted in brackets and utterances such as 'uhm' be included in the transcript to get as close as possible to the participant's accounts. Data that was not going to be analysed, did not require transcription (O'Connel & Kowal, 1995), such as the introduction and ending of our meeting. It was at this stage that I anonymised participant details. The transcribed data was placed in a landscape word document, leaving enough room on either side of the page for comments to be made. Each line of the transcript was consecutively numbered to aid reference during analysis (Appendix H).

Although Finlay (2011) advises IPA is rather a way of being with the data rather than a strict method, there are a number of ways of approaching the analytical process. I followed the steps laid out in Smith et al (2009). I initially began by selecting one of the six completed transcripts that I believed held the most detail. I then proceeded to immerse myself in the participant's world by reading this transcript whilst listening to the matching audio recording, to help remember the nuances of the participant's voice. I then read the transcript a further time whilst imaging the participant speaking in my mind. At this stage, I wrote down any thoughts that came to mind such as anxieties I had about the way I had conducted the interview and further thoughts and questions.

This bracketing helped remove these distractions, from my focus on the participant's words. I was mindful however that by the very nature of my engagement with the data it would always 'bear' my 'mark' (Yardley, 2000, p182).

Following this, I read the transcript a further time and with an open mind began to write my initial exploratory comments about the data. There were no rules as to what I could make note of, yet in order to organise myself throughout this process, I broke these comments down into those that were concerned with the descriptive, linguistic and conceptual aspects of the data. These comments were colour coded; blue, green and pink respectively. I started this process using coloured pens on hard copies of the transcripts, but later found it more comfortable and clearer to type my comments instead. The descriptive comments focused on the content of the participant's interview and what they were describing. The linguistic comments focused on the participant's use of language, non-verbal or otherwise, such as laughter or use of metaphors. I also used linguistic comments to highlight when participants used emotionally charged words such as 'furious'. Lastly, conceptual comments were made, moving towards the more interpretative understanding of participant experience. I also underlined words and sections of transcript that I felt were important and used the technique of free association whilst writing these exploratory comments. This process was time consuming and overwhelming, but also engaging and rewarding.

From these extensive exploratory notes, I began to develop my emergent themes, which consisted of phrases or words that I believed appropriately titled or captured the essence of the participants' experience (Smith & Osborn, 2003). I initially listed these emergent themes in the right hand column of the transcript. Once I had completed this process I typed up these emergent themes and

listed them in chronological order. My next task was to try and find connections between them by clustering together the themes that I thought linked together, which were then loosely labelled. There is no one way of deciding how to group these emerging themes, however techniques I utilised included abstraction and polarisation. At this stage some emergent themes were put to one side due to the nature of the research question (Smith et al., 2009). The themes were then compared to the corresponding participant transcript to ascertain whether they were still reflective of participant words.

Due to the idiographic nature of IPA when moving on to the next five participant transcripts, I attempted to approach them as individual cases, bracketing off the previous, allowing for new themes to emerge in their own right. The final task was to try and identify patterns and connections between the emergent themes, across all participant cases. It was at this stage that I recruited the help of a colleague to help check the plausibility of my claims (Smith et al., 2009). At the end of analysis, four superordinate themes and eleven corresponding subordinate themes emerged.

2.2.7. Reflection on Analysis

During the analysis process I found myself inundated with thoughts about the data and often felt overwhelmed and confused about how best to conceptualise what I believed was emerging from participant experiences. Through use of a process journal I was able to examine and put aside some of these thoughts. However, as I immersed myself further in the participant stories, I noticed myself becoming unexpectedly protective towards the Counsellors and their clients, listening to their stories and the impact the work had on them. Grateful for their participation and in admiration of

the honesty of their journeys, I found it uncomfortable to dissect and rearrange their words. Furthermore, I felt an increasing sense of responsibility to do justice to their narratives and a desire to 'get it right'. Both of these feelings appeared to be similarly expressed by the practitioners towards their own clients and I wondered whether I felt this way, in part, due to the countertransference between us. I continued to remind myself of the co-constructed nature of IPA, that there was not just one right answer and that my interpretation would be different to that of another researcher, for example someone who had experienced the phenomena themselves. I held tight to Smith's idea that the analysis just had to be 'good enough' (Smith et al, 2009, p 81).

2.2.8. Assessing Quality and Validity

It has been argued that with the rapid growth in application of qualitative research methodologies in a wide variety of fields, particularly in Counselling Psychology (Morrow, 2007), it has become increasingly necessary but ever difficult to assess the quality and validity of this work (Yardley, 2000). In Willig (2001, p 16) validity was defined as 'the extent to which our research describes, measures or explains what it aims to describe, measure or explain.' Qualitative methodologies require their own principles for assessing rigour, in keeping with methodological pluralism (Howard, 1983) and it is inadequate to simply measure them against those used for quantitative approaches (Krefting, 1991). In response to debate from both qualitative and quantitative researchers, Yardley proposed four essential but flexible features of good quality qualitative research: 'Sensitivity to Context', 'Commitment and Rigour', 'Transparency and Coherence' and 'Impact and Importance'. These criteria can be usefully applied to the breadth of approaches under

the umbrella of qualitative methodology and are preferred by Smith et al., (2009) in assessing quality and validity in IPA in conjunction with continued independent audit, previously mentioned.

Sensitivity to context can be demonstrated in all aspects of the research process. In the initial planning of this piece of work, there was a purposeful attempt to choose a methodological approach that was appropriate to the research purpose and question, a 'methodological congruence' (Richards & Morse, 2012), as outlined in the 'Rationale for Approach' (2.1.3.). This sensitivity to context is further demonstrated in my engagement with the current literature in this area, in identifying an absence of research, particularly of a qualitative nature. I hope that my sensitivity to context can additionally be seen in the data collection and analysis process; in the empathy and care taken towards participants and their unique narratives during interview, and in the depth and detail of my engagement with analysis (Shinebourne, 2011). A sensitivity to the data is also evident in the extensive use of direct quotes from participants, throughout the completed research, allowing participants to be heard and for my tentative claims to be checked by others (Smith et al, 2009) .

The second proposed guideline, 'Commitment and Rigour' can be seen to overlap with the previous criteria, in that it can be demonstrated throughout the research in multiple and similar ways. Rigour is concerned with 'thoroughness and completeness' of the research (Shinebourne, 2011, p 27). Commitment to the research can initially be shown in the level of attention paid to participants' stories and their level of comfort during the in depth interviews and furthermore in the subsequent commitment to the analysis of the data (Smith et al, 2009). The continued commitment to the epistemology of IPA and the rigour of the research can be particularly demonstrated through the amendments made to the inclusion criteria of the sample during the

research process. Despite endeavouring to recruit a sample as homogeneous as possible, it became apparent that as a result of inexperience as a qualitative researcher using IPA, the inclusion criteria were still too broad. The decision to amend the criteria was difficult and time consuming, but showed my commitment to producing a thorough and robust piece of research. Commitment is also evidenced in my continued consultation with sources of support, such as with supervisors and colleagues, and through the attendance of IPA workshops, initially to learn the necessary skills and later to develop them.

I have endeavoured to format and write up the research in a way that lends itself to Yardley's concept of 'Transparency', which can hopefully be seen in my earlier attempt to thoroughly describe all stages of the research methodology and procedures. My commitment towards transparency is shown through the use of a detailed appendix section and my use of reflexive comments throughout, vital to qualitative research (Hunting, 2014). The 'Coherence' of the research is evident in the congruence or 'fit' between the research question and methodology (Yardley, 2000, p222). However, coherence is best assessed by the individual reader, 'Does it make sense to them?' In reading the final piece of research, I attempted to approach it from the eyes of another to try and answer that question (Smith et al., 2009), which I believe it does.

The final and possibly most crucial criteria that Yardley proposes for assessing quality and validity in a qualitative piece of research, is 'Impact and Importance'. This is the extent to which the research adds value to the given field, whether that be in providing a greater practical, theoretical or socio-cultural understanding. Put simply, it is to answer the question; 'So what?' (Yardley, 2008, p268). Although the degree of usefulness this research has, can only truly be determined by

those at its centre (Yardley, 2000), I have a number of hopes for it. Primarily, by shedding light on counsellors' experiences, it will not only contribute to a richer and current understanding of this work, but also be used as a guide for therapeutic practitioners, for both those already working in this field or for those considering it. I also hope that it will increase awareness of the importance of a sustained spotlight and continued development of mental health provisions for PLWHA, both in therapeutic training programmes and also in wider society.

Chapter 3: Analysis

3.1. Analysis

The following chapter presents the Interpretative Phenomenological Analysis of the experience of six trainee and newly qualified Counsellors as they began working therapeutically for the first time with clients affected by HIV/ AIDS, within specific support and Counselling services in the UK. From this analysis, four superordinate themes and eleven subordinate themes emerged, which are presented in the table below (Table 2). I have selected extracts, shown in italics, which I believe best illustrate these themes. I am aware however that mine is only one of many interpretative choices that could have been made and hope that my attempt to analyse the given data does justice to the experience of the participants, but acknowledge that it will not capture in its entirety.

The included extracts have been referenced using the first letter of the participants given pseudonym and the line number that the extract begins on, for example (G:57) would refer to participants Grace and line 57 of her transcript. Certain utterances, such as 'mmm', that did not illustrate the theme further have been removed and square brackets surrounding ellipsis [...] have been used to indicate where parts of the transcript have been omitted. Words have been CAPITALISED to illustrate participants increased volume during the interview and descriptions of participant behaviour, such as (*banging tabl*e), will be presented in curved brackets. Lastly, XXX's have also been used in place of the name of the HIV/AIDS service or location of the service that is being referenced by the participant in order to further preserve anonymity. For the purpose of this research I will be referring to the participants that took part, who were trainee and newly

qualified Counsellors, Counselling Psychologists and Psychotherapist, as psychological or therapeutic practitioners who offered psychological or therapeutic intervention to their clients, in order to aid clarity.

3.1.1. Superordinate and Subordinates Themes

Table 2. Superordinate and Subordinates Themes

Superordinate Themes			
1. Confronting Expectations	**2. Negotiating Difference**	**3. An Absence**	**4. Transformed by the Experience**
Subordinate Themes			
1.1. Facing Challenge and Complexity: *'Ooh this is going to be (sharp intake of breath)'* (A:144).	**2.1. Encountering Another World:** '*all of it seemed sort of foreign at the time'* (M:36).	**3.1. Missing Education:** *'there was less narrative [...] less discourse for me to hold on to' (J:417).*	**4.1. In the Shadows:** *'it bought up a lot of unconscious material that [...] I thought [...] I'd dealt with but I realised I hadn't' (A:274).*

1.2. Surprisingly Positive - About Life Not Death: '*they're under the very positive cloud of life' (A:202).*	**2.2. Like Any Other Client?:** *'What are we dealing with? If anything different' (J:236).*	**3.2. The Elephant in the Room?:** **'***it's like the HIV isn't there at all' (A:480).*	**4.2. A Sense of Responsibility:** *'I wanna do it justice, working with people with HIV' (R:45)*
	2.3. Needing to be Expert: *'Even though that isn't really my domain, there feels the pressure' (R:56).*		**4.3. Lasting Impact:** *'I realised that I have got immense passion for it.'* *(R:206).*
	2.4. Feeling Like An Imposter: *'they're going to know that I know nothing' (G:203).*		

3.1.2. Superordinate Theme 1: Confronting Expectations

This first superordinate theme aims to encapsulate phenomena that appeared to emerge across all participant transcripts, that of practitioners encountering their beliefs and expectations about the experiences of PLWHA and the nature of the therapeutic work with this client group. It was apparent to me that these expectations, that both attracted and deterred the trainee and newly

qualified Counsellors to the work, were challenged and confirmed during the course of the therapeutic journey. This theme has been further divided into two subordinate themes, 'Facing Challenge and Complexity' and 'Surprisingly Positive - About Life Not Death'.

3.1.2.1. Subordinate Theme 1.1: Facing Challenge and Complexity

When talking about their experiences of starting work within this field for the first time, all four of the six participants referenced a sense of expecting to face a level of challenge and complexity, one which they had not worked with before. The narrative that clients were going to be *'dealing with something that's just so life changing [...] so overwhelming'* (N:506) and that the endeavour of working with it was going to '*push [...] boundaries'* (A:571) in the practitioners, appeared pervasive. I understood from Naomi's extract above, that she was referring to the anticipation of clients being overwhelmed by their experience. However I wondered whether she too felt that she would be overwhelmed in the transference with these clients and what they were bringing to the session. Angela's description additionally evoked a sense of discomfort; that it was going to be difficult and that she would be impinged upon during the process. The anticipation of encountering this client work for the first time, working with people who they understood as having been impacted by something so profound, appeared exhilarating for some participants but left others questioning their ability to cope.

Angela's interview was further laced with references to the belief that her work with this client group was going to *'really stretch'* her (A:242). Again it appeared evident that she believed it was going to make her feel uncomfortable, taking her beyond what she had previously experienced in

her therapeutic work. I imagined like an elastic band being pulled tight, straining under the tension being put on it until eventually released or snapping in two. Angela spoke apprehensively when remembering how she felt about the upcoming work, appearing initially unable to find the words to describe how difficult this was going to be for her, the anticipated discomfort taking her breath away *'Ooh this is going to be (sharp intake of breath)'* (A:144). Having to prepare herself for the undertaking, '*brace yourself Angela, this is guna be [...] deeply [...] traumatic and moving work.'* (A:144). Again I wondered whether Angela's anticipation was in reference to the clients as traumatised or herself as a result of the work.

Conversely, Grace spoke about her desire to actively seek out professional experiences that tested and developed her, identifying her Masters in Counselling as one of these and that undertaking this particular placement just *'added'* to this, that it entailed *'more of a challenge, more excitement'* (G:63). Initially appearing to have embraced this anticipated challenge Grace stated *'I can, I can handle it'* (G:64). The repetition here suggested to me however that she held some uncertainty as to whether she could, handle what she thought was to come and that possibly she was trying to reassure herself. A sentiment similarly shared by Margaret, who expressed that prior to starting work within this placement she had believed that it was going to be *'a bit scary'* questioning herself, '*Can I really handle this?'* (M:161).

The belief that there was something about working with this client group that was more complex and challenging than any other group, also appeared to be held by those around her. When discussing the upcoming placement with friends and family, Grace described experienced some '*negative reactions'* (G:88), which appeared to catalyse a questioning in Grace regarding her

capacity to undertake the work, asking herself '*Have I bitten off more than I can chew?'* (G:86). Although later stating once she had begun, that she had expected it to *'feel bigger'* (G:193), it had not been as unmanageable as she had thought. This feeling appeared similarly mirrored by Jonathan, when he disclosed that he *'thought it would be a little harder [...] more complicated, dramatic'* (J:196), appearing to reference negative stereotypes of the disease, possibly based in his historical knowledge.

Rachel and Naomi however, described quite different experiences where they met the work with great difficulty. Rachel recalled thinking to herself, when undertaking her first therapeutic hours within the placement, *well they're not giving me no straightforward client's here have they [...] they're not easing me in'* (R:390). I interpreted a sense of surprise and a feeling of being overwhelmed, not having had time to acclimatise to the work. This was possibly compounded by Rachel's disclosure that she felt like she hadn't thought *'enough about what it would be like'* (R:452). Rachel went on to describe feeling an almost impossible enormity in what she was working with, it feeling *'bigger than the room', 'like a balloon being blown up'* to *'the point where it's bursting'* (R:1136). Naomi similarly experienced feeling as if her, 'poor little head' was '*going to explode [...] overwhelmed by the story [...] bombarded with [...] too much [...] information.'* (N8:428). It appeared as if Naomi herself felt that she was not big enough, did not have the capacity, to contain the client and the work.

It can be seen that Margaret's experience also reflected this, during her time at her placement she came to think that she had '*heard everything there was to hear'* (M:322) from her clients, suggesting to me that she encountered people and stories that were so shocking and challenging

that she now felt prepared for anything, that nothing could surprise her or be too much in future work. This could be further demonstrated in Margaret's declaration of confidence as a result of this work in the face of upcoming complexity, when starting a new counselling placement in the NHS. Here, Margaret explained that she was going to be working with more acutely unwell clients but claimed *'got it, understand this, know it'* (M:321). However, she later stated, '*if I thought [...] XXX was hard, NHS was way harder [...] so HIV may have meant "Oh my gosh" at the beginning, but now I see borderline clients'* (M:323), her perceptions of this work altered. Research has shown that working with clients diagnosed with Borderline Personality Disorder (BPD) is perceived to be a challenging endeavour (James & Cowman, 2007), Margaret's initial perception that she would experience work with BPD as more manageable than that of with PLWHA, reflects to me not only the level of difficulty she understood she had experienced in her work with this client group but also a shift in her perceptions.

3.1.2.2. Subordinate Theme 1.2: Surprisingly Positive - About Life, Not Death

Following on from the previous theme, there also appeared to be a sense from three of the six participants that they had anticipated that they were about to encounter a world of death and despair when starting working with this client group. Angela stated that she had thought *'death is going to be [...] really at the forefront'* (A:571) of the work, leading the way as the therapeutic focus. It appeared as the work within the placement progressed however, that this was '*not really so much of the big issue'* (A:560). Angela appearing to express surprise at how *'great'* (A:220) and *'positive'* (A:202) her experience had been working with this client group, having believed that she was '*going to be working with people under the cloud of death'* they were actually *'under the*

very positive cloud of life' (A:202). I found her use of cloud imagery interesting however, as although appearing to describe an optimistic experience, it still conjured a feeling of heaviness and burden, it still looming overhead. I wondered perhaps whether working with the prospect of life still felt like an overwhelming and difficult task.

Jonathan appeared to place his experience of this phenomena in the context of what he had previously learned from the literature about working with this client group, expecting *'darkness [...] aloneness [...] depression [...] fear [...] a lot of death and suffering and [...] pain'* (J:103). Jonathan's listing of these powerful negative descriptors indicated to me that his beliefs about this work had already been strongly solidified within him. Possibly emphasising his surprise that his client's presentations were positive and hopeful, he stated '*we don't talk about things being easier these days perhaps, for people that are HIV positive or I didn't know about that'* (J:480). Jonathan's initial use of the word 'we' indicating to me that he perceived it to be globally unknown, a possible felt lack of education in society in regards to the advancements in treatment that have been made and what the reality of living with HIV/AIDS is really like. Jonathan appeared to attempt to make sense of this experience of the therapeutic work, stating it's *'less connected to death and dying'* (J:206) as fewer clients were presenting as *'seriously ill'* (J:202). This absence of death emerged similarly in Rachel's narrative, although appearing to experience something less hopeful that other participants *'I don't know if it's death, but I think there's definitely hopelessness'* (R:1124).

Margaret's experience of death in the therapeutic work also appeared dissimilar to that of other participants. Margaret had initially identified her decision to work with clients diagnosed with

HIV/AIDS due to the affinity she felt with *'loss'* (M:649), disclosing that she had experienced a great deal of death in her life and that she felt she was more comfortable and *'resilient'* (M:291) to it than most, stating *'I get this'* (M:282). Although later recognising that what in fact drew her to this client group was the opportunity to work with difference, it can be seen that Margaret had expected death to be prominent in the work. Whereas other participants had found it death to be missing, Margaret identified that there was a '*constant reminder of [...] mortality'* (M:71) but that she experienced these as '*the thing that wakes them up'* (M:248), HIV/AIDS as a positive opportunity for change not a death sentence.

3.1.3. Superordinate Theme 2: Negotiating Difference

When encountering this client group for the first time, it appeared that these trainee and newly qualified Counsellors encountered a number of differences between themselves and their client. This next superordinate theme aims to illuminate this experience; how this was understood, processed and attempted to be managed. These processes have been conceptualized into three subordinate themes; 'Encountering Another World', 'Like Any Other Client?', 'Needing to be Expert' and 'Feeling Like an Imposter'.

3.1.3.1. Subordinate Theme 2.1: Encountering Another World

There was a strong sense, from five of the six participants beginning work within this field, of coming face to face with a completely different world, manifesting itself in a number of ways. Margaret described that, as part of her training within the service *'there was a lot of talk around*

medication [...] how the medication is improved [...] what it means [...] but all of it seemed sort of foreign at the time' (M:34). It appeared that she was not just meeting with HIV/AIDS for the first time clinically, but engaging with it how it is now following the medical advances in treatment. Margaret stated that it wasn't until she began working with the clients themselves that it *'started making sense'* (M:37), I imagined like trying to learn and use a new language for a country she had not yet visited.

This sense of encountering another world appeared pervasive in Margaret's narrative, where she acknowledged her apprehension when meeting her '*first sex worker client'* having *'never seen one'* (M:336) before. Identifying this client by their profession emphasized to me her feeling of otherness that was felt towards this group. This person was outside of her '*very straight world'* (M:611), alien to her not only in terms of sexuality but also lifestyle. Margaret identified herself as a '*heterosexual woman'* (M:603) and as her experience being *'completely different'* (M:634) from the client group she was predominantly working with, appearing to understand this as the reason for feeling *'alienated'* from the '*sub-culture'* (M:60). A sentiment appearing similarly expressed by Angela when she stated just how *'polar opposite'* (A:236) she felt that hers and the client's life journeys had been. Margaret went on to express that she did not really know the *'contextual information'* (M:58) or the *'behavioural aspects of gay men'* (M:57). Feeling '*overwhelmed with the vocabulary'* and the *'behaviour (sigh)'* (M:62), of clients. Margaret's 'sigh' at the end of her sentence possibly conveying just how overwhelmed she had felt with it all. It could be interpreted that Margaret appeared to reference this feeling as a parallel process between her and recently diagnosed client's, '*they're overwhelmed'* (M:62), also encountering this new world of HIV/AIDS.

Margaret went on to report that she *'couldn't have imagined'* the *'stuff'* she had been told by clients, that these things were so far outside the realm of her world that it was *'shocking',* but also experienced as *'enlightening'* and an *'education'* (M:212). This positive, as well as negative, reaction to this other world can similarly been seen in Angela's narrative, where she stated that she found it *'Fascinating. Fascinating [...] it's just a it's just a just a c- completely different world.'* (A:359). Angela's use of the word 'completely' again suggested just how at odds this felt to her, but her repeated use of the word 'fascinating', emphasised how exhilarating this experience was for her.

Jonathan, who identified as a homosexual man, described that he sensed that for heterosexual society, HIV/AIDS is seen as being *'up over there somewhere [...] outside of our kind of ways of life, but of course that 'it's not'* (J:62). This perceived distance and difference between one world and the other also appeared to be illustrated by Rachel when she spoke at length about the impact of encountering a client recently diagnosed with HIV who was the same age, ethnicity and sexual orientation as her. Rachel remembered it '*really throwing'* her because this person *'didn't fit the gr-demographic',* having only previously worked with a *'massive visible difference'* (R:578) between herself and client. I wondered if this thrown-ness illustrated a shock or discomfort regarding how close this other world of HIV/AIDS, actually was to her. Jonathan also appeared to go on to reference his own 'thrown-ness' with this world, when engaging with the different way client's lived their lives, stating:

'in this organisation a lot of clients identify with different sort of [...] sexual identities and different ways of doing things and there is like a real diversity. In terms of the client group here [...] I heard things that I hadn't heard before, different ways of enjoying sex, different erotic fantasies' (J:375).

This theme can further be identified in multiple ways in Naomi's narrative; initially when she stated *'you just never know what's gonna walk through the door'* (N:505). I interpreted this extract as a real felt sense of unknown about this unfamiliar client group. Even though they all Naomi's clients had something in common, a diagnosis of HIV/AIDS, which to my mind would reduce the expectant uncertainty somewhat, the worlds in which they were coming from still appeared to feel so unknown. This theme can additionally be seen to be highlighted when Naomi addressed the challenges she felt she faced in navigating the therapeutic work with a predominantly black African client group for the first time. Acknowledging that she felt that being in therapy was not typically really part of this '*culture'* (N:22) and that she felt as if she had to be more mindful of her *'immediate reaction'* (N:285) and take into account these differences when presenting her therapeutic strategies, being considerate of their '*world view'* (N:289).

3.1.3.2. Subordinate Theme 2.2: Like any other Client?

Throughout the interviews, all participants appeared to compare and contrast their work with this client group to others that they had experience with. They appeared to try and distinguish the differences and rationalise the similarities between those who did and did not have a diagnosis of HIV/AIDS and what this meant to the work and how they approached it. The following extract

from Jonathan appears to illustrate this initial thought process, appearing to struggle to find the words to figure out what he was encountering, '*what is the, what is the issue here? What is the, what, what are we dealing with? If anything different'* (J:236). Similarly apparent in Grace's experience, having sought out this placement to experience something different, she recalled not actually knowing if it would be different '*to any other community'* (G:307) she had worked with. I wondered whether their search for the answer to this question served to aid a sense of comfort and confidence in the work to come.

Jonathan went on to list the topics brought by clients, describing them as seeming *'usual'* (J:245), with clients wanting to talk about *'my partner [...] an abusive relationship [...] I uhm take drugs [...] I don't know what I want to do in life [...] I've got problems at work [...] I've got problems with my parents'* (J:241). This appeared alike to Angela's experience, whose clients brought *'remarkably similar issues'* (A:351) to that of others she had worked with, with the exception of a *'much stronger focus on "What is the meaning of my life?"'* (A:392) and the *'Chem Sex scene'* (A:350). That Jonathan compared clients with a HIV/AIDS diagnosis against those who did not, indicated to me a felt level of presumed difference between the two and furthermore that he understood those who were without a diagnosis as normative. Lastly, the analysis of these similarities and differences can be seen in Jonathan's questioning over the necessity and productiveness of the specialist status of this work, asking himself whether he believed it '*could be done by a GP surgery'* (J:121), with the same success or not, however concluding that paradoxically, something might be lost, 'normalised' (J:122) in the process if that were to happen.

When Naomi described encountering her clients for the first time and that she asked them to just *'tell me your story'* (N:125), I was struck by a sense of her attempting to meet them where they were, treating them the as individuals regardless of their illness or differences. Later when Naomi discussed the impact that HIV/AIDS had on her in her work, she passionately stated *'they were just people with, with a set (bangs table) of problems and HIV was one of them [...] they're people (bangs table) like you and me'* (N:552). Although acknowledging the biological difference between this and another client group, or even herself, Naomi appeared to minimise the significance the role the disease had in separating them as different. She appeared to strongly believe that this client group, maybe most importantly should be treated the same as any other, indignant and frustrated at the thought of them not. I imagined this as a response to PLWHA's historical experience of stigma and mistreatment. This appeared similarly expressed by Margaret when she stated, *'ultimately, people are people and their hurt is their hurt'* (M:338), her use of the word 'people' emphasising the parallels. Margaret surmised her experience of this phenomena as it really being about the 're*lationship'* (M:163), that that was the priority not the disease.

Rachel's understanding of the differences between this client group and another appeared elusive to her, describing a sense of feeling that *'there is an extra layer there'* (R:278) to the work, however also appearing uncertain of its relevance, *'whether that matters or not?'* (R:280). A further aspect of this theme can be identified in Angela's realisation that thi*s 'could be anyone else with very serious health issue [...] who just happens to be HIV positive'* (A:527). This indicated to me in part, that the diagnosis of HIV/AIDS felt circumstantial to her, the work and possibly the client and furthermore that that this *'extra layer'* would be present in the therapeutic work with any client with a chronic or life limiting disease. This posed a further question of whether there is any felt or

believed difference between working therapeutically with clients with HIV/AIDS or another illness such as Cancer. I understood Angela's revelation that she had a *'sneaking suspicion that [...] they are a little bit more fascinating than other client groups (laughter)'* (A:753), as indication that it was not just the disease itself that differentiated these client's from another group of participants, but also the lives that they had lived up until this point.

3.1.3.3. Subordinate Theme 2.3: Needing to be Expert

All but one participant referenced what I interpreted as the experience of needing to be the expert on HIV/AIDS in order to successfully negotiate their way through the work with PLWHA for the first time. Whether that be an expert on the medication and biology of the disease or the socio-cultural impact that it had had on their clients.

In the first instance, when asked about her level of HIV/AIDS knowledge Margaret stated that she had *'None whatsoever'* (M:117), elaborating; '*I didn't know that a pregnant woman doesn't necessarily, in fact doesn't transmit the disease to the unborn infant. It's only through going through the birth canal that the infant will contract HIV and it's the trauma of the birth or breastfeeding will give the infant HIV'* (M:117). I was initially struck by this information myself, unaware of these transmission route details, but also that it appeared that Margaret felt the need to know these medical aspects of the disease in order to feel like she knew anything or enough of, what it was like for PLWHA. This parallels with Jonathan's admission that he did not know the '*specifics'* (J:483) of the disease, indicating to me that he felt he needed and should know these.

Angela recalled independently *'reading up a lot [...] about the, the, the treatments on offer'* and trying to 'memorise [...] *all the DRUGS'* and '*brochures'* that she had been given by the placement, laughing as she recalled it feeling like she was '*in medical training (laughter)'* (A:173). I got a sense from Angela's laughter of how ridiculous this idea was to her, however, it appeared keenly felt. Angela's raised voice at the word 'DRUGS' signified to me the emphasis and importance she believed they had in the work. I understood this apparent need to know and be able to recall everything there was to know about the medical aspect of HIV as an attempt to ground herself in this unfamiliarity, or compensate for her lack of knowledge or personal and professional experience she felt she had in this field. Although Angela had initially pursued this information on her own, highlighting to me the importance it held for her, this information was also provided by the service in which she worked, possibly adding to the felt need to know it inside and out, that it was expected of her. Angela admitted that she had thought that was what she *'would be dealing'* with and that she would '*need to know about medication'* (A:491) when undertaking this work, I wondered if she expected that clients would be coming to her because she was an expert. Angela interestingly stated however that she had '*not used that knowledge once'* (A:177) and eventually came to the realisation that *'*they were the *expert' (A:336),* on their own lives just like any other client. Concluding, *'I'm not medically trained so they're not going to ask me'* (A:191), this is not my role.

Grace, who had previously spoken about her desire to *'learn something new'* (G:59) at this placement, passionately recalled *'lapping up [...] loads of facts about it [...] and information and data [...] the biology of it [...] and how the drugs work'* (G:112), appearing to really immerse herself in the learning of the world of HIV/AIDS. This list however also indicated to me just how

much it felt like there was to learn. It could be seen that Grace's thirst for this knowledge was exacerbated due to the delay in her receiving this in house training, something which she stated had made her *'uncomfortable'* (G:117), that she did not feel equipped to work with the client group without it. Recalling that when she did receive her training, she requested *'all the slides'* and '*all those pieces of paper'* (G:118) that had been covered. I wondered if this was symbolic, whether Grace felt that if she had the information in her possession then she would feel she had something tangible to hold onto. When Grace spoke of not having understood certain references to the '*HIV community. World. Medicines'* before this, she reported feeling like she '*hadn't tried enough to understand their world'* and was left feeling *'a little bit out of my depth'* (G:130) and *'comfort zone'* (G:185). It appeared to me that Grace felt that learning *'as much as possible'* (G:185) was a prerequisite for working in this field, especially when not having come from that world. I again wondered whether Grace's attempting to be expert was an effort to avoid any discomfort. Grace paralleled this experience to that of beginning to work with '*Cancer patients'*, claiming that she would also not understand *'the treatment or how chemo actually works'* and would also want to '*gather some information. Just to understand the time frame of things or the impact of drugs'* (G:220). It appeared for Grace that encountering any new client group entrenched within the medical field required this extra layer of learning.

Rachel described feeling as if HIV was in '*neon lights'* (R:36), conjuring the image of something shining brightly overhead signalling or warning her of its importance to the client and the work. Rachel stated that even though she knew it was not her *'domain'* (R:57) to know, she still felt a *'pressure'* (R:56) to *'suddenly [...] really kn-, understand [...] show an understanding [...] more so than just someone who hasn't got HIV'* (R:36), be more knowledgeable on the subject of HIV

than the average person or therapeutic practitioner in a different field. As I interpreted it, Rachel appeared to partially understand her feeling that she 'should' know all of this information, due to her conceived position as expert. Working within a well-known specialist HIV/AIDS charity, she stated '*they're guna be expecting me to know'* (R:322). Rachel describes being *'horrified'* at the thought of clients waiting to be *'enlightened by her'* (R:78) and her knowledge of HIV/ AIDS, reporting that even though there were only a few, she struggled to work with information seeking clients feeling unable to *'answer any of [...] questions'* (R:565).

Even after Rachel left her placement she still felt left *'with this sense of I need to know more about that'* (R:308). It appeared that what she did know did not seem to her to be enough; that her knowledge on HIV/AIDS was still elusive and incomplete. She was still not an expert yet; *'I've got a little book which I've called like HIV bible [...] I haven't filled it up yet but I'm like, 'go away and learn about IT. HIV. In isolation. What IT is. Regardless of the person'* (R:314). Rachel's use of the word 'bible' in the above extract signified to me the importance that having this information was to her, to hold onto. Similarly, even after Naomi gained experience working with this client group and realised that *'you, you don't have the answers'* (N:510), she still regretted not having contacted *'THE HIV [...] nurse'* in the town she worked in, so to *'better understand uhm the medical side'* (N:524). Naomi's emphasis on *'THE'*, possibly illustrates her perception of the nurse as the expert and that by talking to her, she would become expert.

Rachel also appeared to experience the need to be the expert outside of the therapy room, feeling the need to *'show off'* her *'knowledge'* (R:21), *'show'* herself '*off in a certain way'* (R:533) to people she '*might perceive to be more knowledgeable, or have some sort of like you now authority*

on HIV' (R:531). During our interview I wondered if this is how Rachel felt with me, that she perceived me as an authority on the subject as researcher and interviewer. I similarly felt that Margaret also appeared to attempt to demonstrate her knowledge to me on a number of occasions, listing what she knew about *'kidney function'* and '*virus load'* checks (M:46), HIV/AIDS medication and how it had developed.

When Grace spoke of her motive for participating in the research itself I interpreted not only a sense that she perceived me as expert but also that she felt that there was still more to learn; *'I thought even meeting you might be interesting to learn a bit more about your research or from where you're coming from with it [...] I guess trying to broaden my own horizons or connecting with people'* (G:8). She was appearing to take any opportunity to immerse herself deeper, understand better and feel more at place in the work.

Lastly when Margaret acknowledged to me that *'it's all well and good'* (M:40) knowing about the medication but that it only becomes *'pertinent as you work with clients'* (M:40), it suggested to me that she felt necessary to be more than just literate on the subject area to feel competent and comfortable to negotiate her way through it.

3.1.3.4. Subordinate Theme 2.4: Feeling Like an Imposter

The final subordinate theme aims to illustrate the feeling that emerged from five of the six participants, that they did not really belong within the service, a sense that they were; not good enough, did not know enough, were not the right kind of person to be working with this client

group. This appeared to leave participants feeling like imposters who would eventually be discovered by their colleagues and clients alike. This feeling initially emerged for Margaret in her fears around meeting the placement managers for interview, worried that she might not be up to par.

'When I first started there was terrified, I, even as I went through the interview I was terrified. Because I didn't really know that much about it [...] I was like 'Oh my gosh, What if I don't even get it because I didn't know anything?' [...] and when I got it there was elation, but then there was more feeling terrified. Because, okay now I really have to do it' (M:25).

Margaret's happiness appeared to turn to fear once she had secured the placement, as now that she was going to have to perform, vulnerable to scrutiny. This sentiment appears particularly significant due to Margaret's admission that she usually considered interviews as opportunity for her to display her abilities, as *'showtime'* (M:83), which she did not appear to feel in this context. Margaret additionally described a nervousness, not knowing how she *'was supposed to do this'* work (M6:136). Indicating to me that she thought that there was a correct way of working with this client group that she did not yet know, that this might give her away. The extract below suggested to me that Margaret felt that there was the difference between herself and these clients, possibly anxious that this would also be experienced by them, that they would also feel that she did not quite belong there.

'there was this fear involved because I didn't know if I'm going to be good enough for this and how are they going to perceive me how am I going to perceive them, am I going to get it right' (M:86).

This feeling of not being the right kind of person to work with this client group can also be seen in Angela's narrative, when she compares herself to her clients. It appears Angela considers her life experience, or her felt lack of it, as a disadvantage when trying to relate to PLWHA and they her. That she believed she had lived an *'ivory tower existence'* (A:101) indicated her sense of disconnection with the realities of what PLWHA, coupled with her derogatory descriptions of herself, further suggested to me that she felt like she was lacking what was needed for this work and that it would be obvious to others:

'I'm [...] w-white, very middle class v-, had led [...] quite a sheltered existence (laughs) [...] and *uhm uh s- sometimes [...] these placements bring in a lot of [...] you know these people have li, really lived. Uh lots of uh they've they've lived sort of on the edge an existence that that that is very very different from mine. And I thought this placement they're never going to take me. I'm I'm you know this sheltered little middle class woman (laughs) from XXXXXXXX. 'What does she know?'' [...]* why why is this placement guna be interested in me [...] *I'm way too middle class and boring and foggy for for this kind of clientele'* (A:70).

Despite the therapeutic hours and experience Angela had accrued during this placement, she conveyed that she still held the belief that '*someone's going to ca- ca- catch me out at some stage'* (A:741). Indicating to me that she felt in the wrong, that she had somehow managed to deceive her

clients and colleagues up until this point. This appeared mirrored in Rachel's experience having *'wrestled with that fraudulent thing even now, like 300 odd hours later. I'm still wrestling with that feeling of, I don't know enough (whispers).'* (R11:270), thinking that *'they're going to see straight through'* her (R:258). I wondered if Rachel would ever feel that she had completed enough client hours or read enough books to ease this internal struggle, that she would always feel inadequate and ill equipped to work with this client group, as she was not one of them.

Naomi asked herself at the time *'What do I really have to say about this?'* (N:507) when referring to the client's HIV/AIDS diagnosis. This questioning possibly suggesting that she did not feel qualified or have the right to comment on their experience, as she did not have the disease herself. Grace alluded to a concern about being exposed by her clients as the imposter she felt herself to be, *'they're going to know that I know nothing'* (G:203). Grace remembered questioning, are they '*going to know that I'm not positive or that I've no idea what that really means'* (G:443). That Grace was not HIV positive herself appeared to feel like a '*barrier'* (G:443), between the clients and herself, she wondered whether it would affect their willingness to talk to her or whether they would *'find it difficult to connect'* (G:203). Needing to have done her *'homework'* (G:189) on this field appeared very important to Grace stating that it was necessary for her to be able to *'look at them in the eye'* (G:187), to prove to herself and them that she was not a fraud. Grace's attempts to know what HIV/ AIDS was, stemming from the fact that she hadn't 'lived it' and didn't really '*know what it's like'* (G:189).

3.1.4. Superordinate Theme 3: An Absence

The third superordinate theme aims to conceptualise the sense that participants strongly experienced HIV/ AIDS to be missing from their experience. These phenomena appeared to emerge in a number of ways from participant narratives; in a felt lack of awareness of the disease in society and media representation, in their therapeutic training and also within the counselling sessions themselves. This theme has consequently been split into two superordinate themes; 'Missing Education' and 'The Elephant in the Room'.

3.1.4.1. Subordinate Theme 3.1: Missing Education

As previously highlighted in 'Needing to be Expert', participants appeared to feel a strong desire to accrue information and knowledge in order to feel comfortable and competent in their work. However, there also appeared to be a prominent sense from participant accounts that they felt that they were missing an adequate and current HIV/AIDS education prior to entering this field, whether that be felt from participants respective trainings or in it's perceived absence in society and their surrounding worlds. All participants remarked on the potential value that this research had to future practitioners in the field and their willingness to contribute to bolstering the literature base.

Grace's acknowledgment that before she started she had only a *'basic knowledge [...] that you get as you grow up and from google (laughter) [...] but nothing more'* (G:105), suggested to me that she felt that her knowledge of the area was lacking or insufficient, as it had been gained from historic, independent and casual sources. As one of the youngest participants, I also wondered how her experience of learning of PLWHA might have been different to that of an older participant,

having grown up at a different time in the HIV/AIDS crisis. Naomi, who stated that she had been interested in and reading about HIV/AIDS since the 80's conversely appeared confident in her knowledge, feeling like she was *'pretty clued'* up on the subject *(N:552).*

Similarly Angela spoke of her knowledge of HIV/AIDS prior to starting as *'completely non exist-virtually [...] expect what [...] you hear on on the news [...] no medical background [...] or parents or [...] family who'd [...] had experience of working'* (A:126) with it. This extract indicated to me that Angela felt that her awareness of HIV/AIDS was almost entirely absent from her life, having no connection to it; her personal and professional opportunities to be informed or learn about the disease were non-existent. Angela recalled the time when HIV/AIDS '*first hit'* (A:127), evoking a sense of a powerful and uncontrollable force, stating that it was her *'era'* (A:144), that it felt and was from a different time. That Angela stated that she had grown up with '*THOSE images of Rock Hudson looking dreadful going into hospital'* (A:147) indicated to me their infamy and the impact on her and possibly others. It also felt like an acknowledgement of the perceived difference in representation between then and now. Angela elaborated further on this, remarking that she was not conscious of when it had started *'fading'* from her awareness and that she was *'hearing less about it'* (A:159). This signified to me that she may have felt the absence of HIV/AIDS coverage in the media in the present day, it feeling as if HIV/AIDS had slowly ebbed out of the public eye and mind. Jonathan similarly remembered the *'horrible stuff'* (J:524) in the commercials of the *'eighties and nineties'* (J:521). Angela's description of having *'this awfully scary disease in my head'* (A:132) indicated to me that the fear around that disease had burrowed deep into her mind and I wondered whether Angela still had the hangover of this *'shock and the exposure'* (A:146) when she entered this work for the first time now. Jonathan also alluded to a sense that people,

including himself, would still hold this historical and stereotypical representations of the disease, '*the ideal [...] kind of AIDS victim or the HIV tragic kind of person who will die'* (J:88).

Jonathan stated that during his work he *'kept being surprised [...] finding out as I went along [...] from clients [...] this is what it is like [...] these days'* (J:483). This reflected to me the felt absence of information available to him about the reality of the disease today, him appearing to have to rely on being drip fed information by the client, never quite feeling satiated. Jonathan elaborated further on his experience, when he stated that he felt that HIV/AIDS was *'not visible in training, it's not there'* (J:569), I imagined him feeling it's presence and desperately searching in textbooks and scanning lecture slides for any small reference, but to no avail. It appeared that the work was more challenging due to this, with *'less narrative [...] less discourse [...] to hold on to'* (J:416), feeling adrift without this to guide and support him. In the following extract from Jonathan, it appeared that this perceived dearth of information also extended beyond HIV/AIDS, to aspects of gender and sexuality. Jonathan lamented this *'lost'* (J:32) learning and opportunity to '*position'* (J:386) the self in relation to these facets in training, as a *real shame'* (J:381). This evoked not just a sense of absent knowledge, but a loss of richness and depth in his experience of the work because of it. It appeared for one participant, Rachel, that the opportunity she had had so far to explore her work had also not been enough, her needing and wanting more 'space to reflect on my [...] working with people living with HIV' (R:9), motivating her to come forward for this research.

Margaret, who had identified her limited previous learning as having come from a friend who worked in the medical field, similarly reflected on her therapeutic training, stating *'we're not really taught how to deal with people with [...] disease [...] sickness [...] whether it's Cancer, whether*

it's Diabetes, whether it's HIV' (M:585). Her experience indicates an absence of education relating to the psychological aspect of all illnesses. Conversely however, from Margaret's repeated use of the word 'specialist' in the below extract I sensed that she felt that this specific subject area particularly requires extra focus and attention in training to avoid a loss not just for practitioners but also clients. I also wondered whether maybe this is why it felt more absent in her experience, having not received specific and relevant training.

'I think it's a very specialist subject (pause). I feel that if there is more emphasis on it and more understanding of it, it would not just help the client group, which I think is a very specialist group... it also help the Counsellors and th-psychotherapists' (M:3).

3.1.4.2. Subordinate Theme 3.2: The Elephant in the Room

This next subordinate theme aims to illuminate practitioner experience of HIV/AIDS as missing from the therapeutic work with PLWHA within these specialized HIV/AIDS services. Although participants appeared alert to its presence and the impact of the disease, it emerged that it felt often left unspoken about by their clients, leaving practitioners unsure as to why this was and if it was necessary to discuss at all. This phenomenon brought to mind the idiom of 'The Elephant in the Room', a phrase referring to moments when important issues are left unaddressed due to the difficulty or embarrassment of doing so from both client and therapist.

Jonathan expressed being met with surprise when he found that *'it's, a lot less of a, an issue [...] than we might think it is before doing this kind of work'* (J:83) and that *'people talked about it a*

lot less [...] to the point where I'll quite often find myself bringing it up [...] with client's, to check it out [...] talk about it and see what goes on' (J:68). From this extract it appears that Jonathan believed that the disease was going to be the main focus in therapy, confused and surprised that clients did not directly talk about the impact that HIV/AIDS has had on their lives. It appears that the absence of this in the room was so strongly felt that he was compelled to bring it up himself, curious as to the status the disease held in the client's life. Jonathan attempted to rationalise why the disease felt so *'elusive'* (J:180) in his sessions, postulating that the disease had become *'less of a worry, less of a [...] charged sort of topic and maybe there is less of a need to talk about it as well'* (J:95). I interpreted that Jonathan's growing awareness of the advancements made in the treatment of the disease informed this, an understanding that it is no longer a death sentence.

Grace similarly appeared struck with surprise, stating how *'remarkable'* it was that clients had been managing so well for so long, that it was almost like *'the HIV isn't there at all'* (A:479), in the room, in their bodies, in their lives. I wondered whether or not this feeling was also shared by her client's, were they coping as well as she perceived. Grace stated that she had *'expected more talk around a client's HIV or [...] more links back to their HIV or their HIV experience'* (G:262) unable to *'remember the last time it was mentioned'.* It felt as if Grace spoke about the disease as if it was missing, that it should have been present. However it appeared that the lack of discussion around it eventually became normative for her, it quietly disappearing into the background of the work, much like its presentation in the media and its presence in our minds. This felt similar to the experience that emerged in Margaret's story, of the disease as initially present only to become *'less prevalent'* (M:414) as the weeks passed. It reminded me of my own therapeutic work and the naturally changing presenting issues of clients. However, I also wondered if this dissipation of

HIV/AIDS from the room was as a result of it being confronted early on in the work. Grace further elaborated that she had realised that *'actually [...] it doesn't need to feel as big between two people [...] something that limits people connecting'* (G:448). It appeared that Grace had expected this disease to loom over them, permeating all aspects of the therapeutic work and relationship, and for it to feel like more of a barrier between her and her clients relationship, herself without a positive diagnosis. It was Grace herself who had imagined this distance between them.

This theme is similarly apparent in the narratives of Rachel and Naomi. Rachel states *'it's not just about HIV, far from it'* (R:479) and Naomi's realises that HIV/AIDS *'wasn't always the priority'* (N:375) in her clients lives. The impact of an HIV/AIDS diagnosis cannot be dismissed. However, it can be seen that that these participants no longer perceived HIV/AIDS as being at the centre of their clients worlds. These practitioners appeared to have gained an awareness of the other battles their clients were facing that were just as, if not more pressing than their diagnosis. I wondered however whether this experience of it as absent may also have illustrated a rationalisation of an avoidance of these issues from their clients and possibly themselves, allowing these issues to remain the unspoken. I felt this was further represented in Margaret account of the start of her work, when she stated that she didn't *'really want to ask [...] didn't really want to know [...] it's a little bit too personal'* (M:203). Topics such as transmission route and sexual practices appeared to feel too uncomfortable to ask the clients about and easier to be avoided. This avoidance can comparably be seen in Angela's experience, she appears surprised having been unaware that she had not addressed certain topics, asking '*Didn't we?'* (A:310) when multiple clients highlighted to her that she had not addressed certain aspects of their lives in the therapeutic work, specifically sex and relationships.

Finally, although Rachel experienced that for some clients, *'HIV never entered the room'* (R:485), I sensed that for other participants the disease was experienced as holding a unique position of being both present and absent at the same time in the work. Naomi describes it as not necessarily being spoken about at every session but as *'always there'* (N:332). I imagined her, consciously and unconsciously, holding an awareness of its existence in the back of her mind, occasionally being remembered when referenced by herself or her client. Jonathan appeared to elaborate on this felt sense of the diseases omnipresence in the work, describing it as *'everywhere',* as being in the *'leaflets'* that sit in the room between himself and the client. That even when HIV/AIDS was not literally or physically brought into the room by either of them, it was *'already here'* (J:149). I imagined it's presence as felt by both of them in the very fact that the counselling service was specifically tailored to PLWHA, it is already assumed or known to be there. Jonathan appeared to understand this as the reason why *'perhaps it doesn't need to be disclosed in the same way'* as something else would, that it did not need to be talked about in the same way as it would be in a general counselling service.

3.1.5. Superordinate Theme 4: Transformed by the Experience

The final superordinate theme has been conceptualised as a sense that practitioners felt as though they were both momentarily and permanently affected by the experience of working with this client group. Transformed emotionally and professionally by the clients themselves and what they brought into the work. This superordinate theme has been split into three subordinate themes that

best illustrate this phenomenon; 'In the Shadows', 'A Sense of Responsibility' and 'Lasting Impact'.

3.1.5.1. Subordinate Theme 4.1: In the Shadows

It emerged that throughout the therapeutic work with this client group, five of the six practitioners were confronted with aspects of themselves that they felt uncomfortable with or with topics which they considered taboo, hidden in the darkness from themselves and avoided in their client work. Aspects that appeared most prominent in this sense were sexuality and shame, the subordinate theme 'In the Shadows' attempts to illustrate the practitioners encounter with these issues and the resulting impact it had on them.

When Angela first described the difficulty she felt in being '*forced' to* face her own *'Shadow'* (A:106) during the early part of her work with this client group, she appeared to be referencing Carl Jung's 'Shadow' archetype; the parts of herself that she was not conscious of or had difficulty confronting (Jung, 2003). That Angela's described this process as one that was forced, indicated to me that she may not have been entirely comfortable or willing participant in this, evoking a strong sense of discomfort. Angela had stated that due to her upbringing, her Mother was a health professional, she had firmly believed that sexuality was *'not part of my shadow [...] no, no, got nothing of that'* (A:253), confident in her abilities to address this topic. However, it appeared that when she came face to face with the therapeutic work with PLWHA she encountered '*a lot of stuff*' that she thought she had '*dealt'* with, she was in fact '*not yet as fine'* (A:274) with as she thought she was with it. It appeared that this work held a mirror up to her and the parts of herself that she

had not previously been able to see or willing to admit were still there. I wondered if, as illustrated in the subordinate theme 'Another World', that Angela also perceived HIV/AIDS to be *'over there'* (J:62) as Jonathan had felt it was seen by others. That the aspects the work it related to did not and would not touch upon her or at least not to the extent which they seemed to have done. Angela appeared to have come to understand that she experienced these encounters with sex and sexuality more significantly at this placement due to her perception of the relationships of PLWHA as *'always more complicated'* (A:289), that there was an extra layer there for them both to uncover and wrestle with. This reminded me of Jonathan's understanding that he was *'working with something that's in bed'* (J:451) with this client group. This evoked not only a sense of confronting the felt intimacy between himself and the client, but also highlighting to me that no matter their clients sexuality or transmission route, this disease now impacts how these clients think about and have sex. This is similar to Jonathan's understanding that the disease is always present in the work, even when it is not, so too is the topic of sex and sexuality. Although attempts might be made by individuals to hide this aspect of themselves in the shadows from others, it is always lays beside them in bed and in the therapy room.

Grace's narrative further appeared to elaborates on this, when she described the discomfort and anxiety she discovered she felt in discussing explicit aspects of her client's sexual life to her university supervision group, asking herself *'Will it be okay?'* (G:582). She described herself as *'cautious'* about the fact that she was going to be '*bringing sex into the room'* (G:584), worried about others reactions to this taboo topic as it was not usually discussed there, particularly perhaps as Grace disclosed that her therapeutic training was delivered by a religious organisation. I was

struck by this reaction and wondered if she had felt the same when bringing it to supervision within the counselling service.

The concepts of shame and self-loathing appear to have personally arisen for two of the therapeutic practitioner during the course of their work. Rachel appeared to connect strongly with her client's and their aggressive sense of self-loathing, *'it activated a lot in me I think [...] on a personal level [...] my own loathing'* (R:1006), appearing deeply affected by these encounters. Rachel's identification with her clients could be seen to emerge in her therapeutic work with them, when she found it hard to maintain her role when her clients were *'referring to themselves as dirty',* as *'feeling infected'* and that *'they wanted to rip their skin off'*. In these moments she felt the need to *'do something radical'* (R:1009) in the room with them at that moment, it was so unbearable for her to hear. Her descriptions of what her client's wanted to do to themselves left her nauseous, it felt as if their words had really gotten under her skin and infected her.

Angela similarly described an experience of being confronted with her own shame during the work, detailing a specific moment of connection with a client where she felt she had more than just a surface level, cognitive understanding of their experience of this emotion, but that she could actually feel it in her core; *'there was a point where I remember [...] I thought 'Oh gosh, yeah I I get this. This is sort of embodied knowledge rather than 'Oh yes (high pitched) shame, yes I get that'* (A:640). It seemed that Angela had previously been aware of this aspect of herself, maybe having already attempted to address this issue in her own therapy. It appeared however that its memory had been forgotten, whether intentionally or not, its intensity dulled until this moment of meeting with this client where it was awoken

The experience of encountering aspects of themselves, that they were not aware of or found difficult to address, also appeared present in Jonathan's narrative. It emerged that Jonathan had had to play a very active role in working on these parts of himself during this time at this placement, and although challenging, described it as a *'very useful kind of rich journey emotionally'* (J:446). One that he got a lot out of.

'I noticed that like I had to work on myself as I went along on what I thought about these issues, how I saw my my own sexuality how I uhm positioned myself [...] To a, a greater degree than other places. Made it harder work and interesting but harder' (J:447).

Margaret similarly spoke of what appeared to be a developed sense of personal and professional self as a result of encountering certain aspects of this client work, stating that she had become *'much more comfortable in my own skin now'* (M:399) as a consequence. This description evoked a sense of an improved confidence, appearing to have previously felt uncomfortable with certain elements of the work. Margaret concluded that, *'I'm not so shockable anymore'* (M:401), conveying the impression that during her time there she had been faced with the unusual, the taboo, the unspoken and that as a result of that experience, she felt stronger.

3.1.5.2. Subordinate Theme 4.3: A Sense of Responsibility

The next theme that developed in four of the six participant's transcripts, was that of the strong sense of responsibility from the practitioner towards their clients, a responsibility that appeared to

go above and beyond the relationship within the therapy room; a need and desire to advocate for PLWHA, to educate others of their clients experiences and the ability to defend them against societal stigma. Rachel spoke of wanting to do *'it justice, working with people with HIV'* (R:45) and that she felt a sense of '*protectiveness'* towards her clients (R:90). I interpreted from this that Rachel was more than just conscientious about her therapeutic work, wanting to do a good job, but rather that she felt an extra level of responsibility towards this client group due to the discrimination and abuse they had faced. I believe this can be demonstrated through Rachel's statement, '*I'm aware of [...] experiences that people have had [...] so therefore I feel like I've got a duty'* (R:93) appearing to want to do better and be a staunch ally. I also wondered whether her need to protect her clients, the 'care' (R:96) that she felt towards them, was a response to the impact that the therapeutic relationship had had on her.

Rachel further acknowledged what appeared to be a felt internal *'pressure',* when she stated that she felt like *'people might look to me to, to educate them on HIV' (R:90),* that it felt like it was her job due to the very fact that she had worked with the client group. I wondered whether this sense of responsibility to lead the way for others was emphasised due to Rachel being the *'only one'* on her course *'working with this particular client group'* (R:3). It appeared that there was no one else there to shoulder this weight with her, so she may have felt like the only mouthpiece for the client's voices to be heard. Jonathan's experience of sharing his therapeutic work with his colleagues, can similarly be seen to mirror this when he stated, *'it gave other people an opportunity to think about something that we haven't talked about in the three years of the training [...] it was a [...] definitely positive experience [...] there was a lot of interest'* (J:41). This being his fellow trainees first

opportunity to discuss the topic of HIV/AIDS he appeared to both feel an honour but also the responsibility that I was seemingly down to him to inform them and answer their questions.

I believe this theme of responsibility can similarly be seen through Grace's narrative, where she identified her desire for more and more information on HIV/AIDS in order to better equip herself to educate and inform others, stating *'if I stayed with this placement and continued to speak to other people [...] I could then give them the facts [...] not say, 'Don't be judgemental that's horrible'.'* (G:107). It appeared Grace felt the need to be able to appropriately defend her client group, by more than just appealing to others' sense of what is right and wrong. Grace experienced fellow trainees '*very bluntly'* stating that *'they wouldn't want to work within that sector' (G:43)* seeing first-hand the stigma and avoidance felt by her clients. The sense of duty that developed towards PLWHA in response appears keenly in the following extract when Grace stated: *'if I can do something in there, then I should do it [...] maybe it's not everyone who will'* (G:76). This did not present to me as a feeling of an unwanted obligation, but rather a desire and privilege to be able to contribute towards the cause

Margaret similarly recalled during the interview, a situation where a colleague had said to her '*Ewww, do you shake their hand?'* (M:366) which prompted an incredulous and defensive response from Margaret at the reduction of her clients just to the disease, *'"Oh my goodness", that's a person'* (M:367). As others had and would reject these clients Margaret seemed to feel an increased understanding of the importance of behaving differently or making an extra effort to help repair these wounds for PLWHA, compensating for the behaviour of others. Margaret would most

definitely shake her clients hands, despite her Psychoanalytic training advising against it, if it meant that it was telling that person that *'they're okay'* (M:360).

3.1.5.3. Subordinate Theme 4.2: Lasting Impact

The following extracts aim to convey the final subordinate theme that appeared to emerge from all participants narratives, of being unexpectedly affected by the work with this client group, which promised to remain with them well beyond their time at the placement. As a result of this experience participants appeared to feel a surprisingly strong attachment to their clients and the HIV/AIDS community as a whole. Margaret stated that *'you do love these people [...] you build a relationship with them'* (M:527). I wondered whether or not Margaret felt this more acutely with this particular client group, compared to another, due to the often intense subject matter. That what was brought possibly excelled this process. This also appeared to emerge as the case in Naomi's story, where she stated that she felt it, the relationship and the work, was *'easy to […] get caught up in'* especially when trusted 'w*ith some very heavy stuff*' (N:572) by clients in the sessions. These powerful emotions and stories shared by the client with Naomi appeared to unintentionally, but quickly solidify their bond and the care that she felt towards them.

Naomi's continued description of how *'VERY painful'* (N:543) it had been for her whenever a client refused to take their antiretroviral medication, evoked a sense that their pain was also her pain. I imagined much like a mother would with her child, wanting them to live as long and happy life as was possible, but also having to let them make their own difficult, possibly destructive decisions. Similarly Rachel and Margaret both similarly went on to fondly refer to their clients as

if they were family. Rachel described the Counselling placement she worked in as '*a home'* for her clients, one that she couldn't help feeling '*part of the family'* in (R:1203), demonstrating an undoubtable closeness between them and the work. When Margaret remembered an occasion when one of her clients arrived at their session accompanied by their new baby, she exclaimed *'I feel like an Aunty'* (M:521). It appeared that the love she felt for this client and the relationship she had built was truly meaningful and long lasting.

Rachel further, spoke emotionally about how she felt that there was something *'special'* (R:909) about this work, recalling a particular client that she claimed would '*stay with'* her *'throughout*' (R:1170), appearing to refer to its profound effect on the rest of her professional career, as well as its personal reach. The following extract focuses on her understanding of the impact of this experience on her and what qualities it unlocked within her;

'I must be able to access strength like that [...] I must have that depth of strength somewhere [...] Cos I've just witnessed it in someone else. That I, and unbelievable amount' (R:1183).

It also appeared that both Rachel and Grace had discovered by chance, their '*immense passion'* (R:207) for working in this field, having both similarly stated that it was '*not a sector that [...] I really want to work within [...] at all.'* (G:8) and that there was *'no prior interest in, in working in that field at all'* (R:208). Their identical use of 'at all' struck me as to the confidence they had felt in these statements, this was not a world that they had thought was for them. It came to light however that Grace now felt that she *'would probably have jacked it in by now'* (G:281), if she hadn't of had this placement. The time commitment of her therapeutic training had been such a

challenge for her to manage, but the client worked had kept her engaged and motivated. Grace further expressed that she felt that '*we still need to keep going. We need to do more'* (G:155) in this field, her use of the word 'we' demonstrating to me the degree to which she now felt invested in it. Rachel additionally stating that her '*connection*' (R:132) with this arena was never going to stop, even when she ended her placement, attributing her time there as having *'shaped'* (R:887) who she was as a person and practitioner.

The lasting impact that this work had is seen in Angela's stated belief that in this work, *'you get the clients you need'* (A:269). That what she had experienced, may not have been the easiest but had been the most valuable to her, both professionally and personally. Similarly Margaret stated that she had *'learned something from every single one of the'* (M:317), things that she would take forward with her throughout her life.

Chapter 4: Discussion

4.1. Discussion

This chapter will initially begin with a summary of the research findings and will then go on to locate them within the current literature on this area, as highlighted earlier in the review. Specific focus will be given to the significance of knowledge on participants experience and the issues of working with discomfort in therapeutic practice with this population. I will then go on to discuss the clinical implications of this research to Counselling Psychology and the identified limitations and the possible areas for further research.

4.2. Overview and Summary of Results

The aim of this research was to qualitatively explore trainee and newly qualified Counsellors, Psychotherapists and Counselling Psychologists experience of encountering therapeutic work with clients diagnosed with HIV/AIDS for the first time, within specific HIV/AIDS support and counselling services currently within the UK. With limited qualitative and recent research on this topic, my hope is that it will bridge the gap in practitioner, trainer and supervision knowledge of what it is like to work in this field for the first time as a trainee. As a result six practitioners were interviewed by means of a semi-structured schedule and their transcribed narratives analysed by means of Interpretative Phenomenological Analysis. From this data four superordinate and eleven subordinate themes emerged that I interpreted as most pertinent to the participants experience of

this phenomena and of most ‘Impact and Importance’ (Yardley, 2000) to the field of Counselling Psychology and the current status of mental health support for PLWHA within the UK.

The first theme was conceptualised as ‘Confronting Expectations’ and had two corresponding superordinate themes; ‘Facing Challenge and Complexity’ and ‘Surprisingly Positive - About Life Not Death’. These themes attempted to conceptualise the experience that appeared to emerge from participant transcripts, that of the coming face to face for the first time with their perceptions about the world of HIV/AIDS and the people within it. It appeared that these participants pre-existing beliefs, both known and unknown to them at the time of starting work within this field, coloured their understanding of the work to come. There was an apparent anticipation of a challenging and complex client group that would test their limits personally and professionally and whose primary therapeutic focus would be centered on loss, despair, hopelessness and death. This theme tries to illuminate how these expectations were both challenged and confirmed during their time within this field.

The following theme, ‘Negotiating Difference’ had four underlying subordinate themes; ‘Encountering Another World’, ‘Like Any Other Client?’, ‘Needing to be Expert’ and finally, ‘Feeling Like An Imposter’. These themes aimed to illuminate the psychological practitioners endeavour of encountering a new world that they perceived as completely alien to them, and the resulting feelings and meaning making that arose from this. It appeared these practitioners attempted to try and reconcile the differences they experience in this client group against other groups in an attempt to find some sense of familiarity. Furthermore it emerged that practitioners felt both an internal and external pressure to be expert on the subject of HIV/AIDS in order to feel

competent; despite these efforts however, they continued to feel an overpowering sense that they did not know enough and did not belong in this field.

The third superordinate theme that emerged was entitled ‘An Absence’ due to the overwhelming sense that HIV/AIDS was felt as missing from the worlds of the practitioners. Although this arose in multiple ways, it appeared most prominently in the felt sense participants had of a ‘Missing Education’ in respect of their therapeutic training and a lack of media and societal awareness of the disease and its developments. This theme also appeared to emerge in the therapeutic practitioner experience of HIV/AIDS as surprisingly missing from the therapeutic work, its apparent relevance to the client’s lives and thus what they did, or did not bring to the session. Although participants appeared keenly aware of the presence of the disease, it appeared mostly unspoken about by their clients, so entitled ‘The Elephant in the Room’.

The final superordinate theme that appeared to emerge from the data was entitled ‘Transformed by the Experience’ which was further organized into three subordinate theme; ‘In the Shadows’, ‘A Sense of Responsibility’ and ‘Lasting Legacy’. These themes attempted to represent the deep sense that these trainee and newly qualified Counsellors, Counselling Psychologists and Therapists appeared to feel as if they had been altered in some way through the process of undertaking this therapeutic placement and engaging with the client group. As a result of this work it appeared that participants had faced aspects of themselves that they had been previously unaware that they had difficulty with, such as sexuality and shame. Furthermore it appeared that as a result of their experiences here, these practitioners developed a new found sense of responsibility towards this

population group and a continued desire to continue working within the field, much to their surprise.

The above themes depict practitioner's core experience of starting therapeutic work with this client group as one of being fraught with apprehension and contradiction. Their anticipation of anxiety and discomfort in their experience, appearing inextricably linked to their existing assumptions and knowledge, or lack of it. Expecting to find only death, despair or the disease all encompassing, only to be met with life and hope or the absence of HIV/AIDS. The significance of this knowledge and participant preparedness to face this discomfort will be at the focus off the rest of this discussion.

4.3. The Significance of Knowledge

The felt absence of knowledge can be suggested to be seen throughout multiple subordinate themes, but particularly 'Needing to be Expert' and 'Missing Education'. As outlined in the literature review, knowledge has previously been identified by trainee counsellors as a perceived factor in their levels of comfort (Richelle, Heard & Yurcisin, 2018a) and confidence (Harris & Hays, 2008), when working with clients with HIV/AIDS. In the research of (Richelle, Heard & Yurcisin, 2018a), it was specifically identified that biological and medical information such as; medication and transmission routes as well as knowledge gained from a prior personal connection with the disease; from a friend or family member, was inextricably linked to this felt comfort.

In a further study of Richelle, Heard & Yurcisin (2018b) the knowledge and beliefs of counsellors was again identified as a possible challenge in working with families where there was a diagnosis of HIV/AIDS. Here it was identified that student counsellors believed that they 'would need to be very knowledgeable about the disease, its processes, the treatment, social stigma implications for individuals and their families living with it', and perceived that 'not knowing enough about HIV/AIDS' as being an issues in the work with this population (Richelle, Heard & Yurcisin, 2018b, p171). From participant narratives in this research it appeared that there was a great deal of unknowns and uncertainty about entering this field for the first time. It could be suggested that this was particularly felt due to the early stage of their training and limited clinical experience, as seen in Skovholt & Rønnestad (2003). However, participants here similarly appeared to strongly identify a sense of wanting and needing to accrue knowledge in order to be the expert in all aspects of this field, the; medical, biological and socio-cultural understanding. Participants Jonathan and Angela, acknowledged a need to know the '*specifics'* (J:483) of the disease, the transmission routes, the *'DRUGS'* (A:173) before they could adequately work with this client group. With Margaret believing that she had no knowledge '*whatsoever'* (M:117) at the start, due to the fact she did not know the exact route of HIV transmission from mother to child during birth.

The apparent motive for this information expedition, was to increase practitioners sense of comfort, competence and feeling of deserving to be in this role with this population. With Grace identifying that when she at first did not have a biological understanding of the disease, she had felt like she '*hadn't tried enough'* (G:130) and was out of her *'comfort zone'* (G:185). Rachel further expressing feeling *'horrified'* (R:78) at the thought of clients attempting to seek information from her during her sessions, finding these encounters more of a struggle than any

other. As previously highlighted, it has been found that individuals seeking care at specialist STI services, do so in part for their perception of expert treatment (Balfe & Brugha, 2009). In this research it also appeared that it was felt by practitioners that there was an expectation for them to know more, to be expert. As well as feeling an internal pressure, participants identified a sense that '*they're guna be expecting me to know'* (R:322), that both client and placement expected them to know everything there was to know. I would suggest that research on this experience, would be valuable for HIV/AIDS counselling and support services to be aware of for new practitioners, in order to enable an open conversation about what is expected from them in terms of their knowledge and its use.

In (Werth & Carney, 1996) it was identified that trainee Counsellors require a strong foundation in HIV knowledge, specifically the terminology, transmission and treatments. This similarly appeared to compare to participants understanding of what they felt they needed, but did not get from their therapeutic trainings and which appeared to have felt delayed in a number of their Counselling placement. in order to feel adequately prepared to undertake this work with this client group. Interestingly however, many participants disclosed in this research that they had '*not used that knowledge once'* (A:177), or at least not as much as they thought they would.

Despite this however, this research appears to also highlight that even though many of the participants sought and gained the knowledge they felt they needed to work in this field, they actually never felt satisfied, never feeling like they knew enough. Rachel and Naomi were left *'with this sense of I need to know more about that'* (R:308), still wanting to speak to the 'experts' well after their placement had finished. I wondered whether this was in part due to the, strongly

felt, difference and distance these participants appeared to experience between themselves and their clients. In my analysis I had understood this as a compensation for a lack of personal and professional knowledge and contact with this client group. It has been identified that practitioners might find it more difficult to empathise with this client group, an "inability to grasp the essence of the [...] lived experience' (Richelle, Heard & Yurcisin, 2018b, p173), where there is limited knowledge or experience with the disease. This appeared to be most significantly demonstrated in the subordinate theme 'Encountering Another World', that addressed the complete '*alienation*' (M:60), that participants appeared to feel in regards to HIV medication, sexual lifestyle and cultural differences.

Similarly in (Rose et al., 2015), Counsellors identified their HIV/AIDS knowledge did not come from university teachings and although highlighted in (Melton, 1991) that it is the responsibility of the practitioners to educate themselves in areas of HIV AIDS that are missing from their training, it could be argued that this demonstrates that trainee counsellors are being let down in this respect, and were being insufficiently prepared to work with this clients group. The current piece of research appears to complement this earlier research, going in some way to begin to highlight sources of knowledge and information that participants utilized in order to fill these felt gaps. The subordinate theme 'Missing Education' illuminated the experiences of participants having accrued their knowledge historically, from the media but additionally feeling that there was information available to for them to grasp onto.

4.4. Working with Discomfort

It was found in (Sherr., et al 2008) study, that lack of disclosure by individuals with a positive HIV status were twice as likely to express suicidal ideation. Although participants of this study were working within HIV/AIDS specific services within the UK, where the individual's positive status was all but assumed by their being there, this research identified a lack of discussion surrounding the disease between client and practitioner. This absence appeared to be felt by practitioners from their clients and they attempted to try and identify reasons as to why this might be, such as; it being lower on their clients list of priorities to discuss or a complete avoidance altogether, parallelling it to their clients experience outside of the room. It also appeared however that there was avoidance from practitioners in addressing not only HIV/AIDS but also other topics such as sex and sexuality, both within themselves and the therapeutic work. This appears particularly evident in the subordinate theme 'In the Shadows'. Although it has been suggested that these topics are always in the therapeutic work (Diambra, Pollard, Gamble & Banks, 2016), particularly so for this population perhaps, these findings appear to parallel those identified in (Hilton, 1997). Here it was found that avoidance of sexuality in the therapy room was common in work both with PLWHA and those who were not. It has been suggested that before Counselors begin working with this client group, they be given the opportunity to develop their "inner ear" in regards to their attitudes towards PLWHA, to question themselves on their response to being diagnosed in order to improve awareness of countertransference (McKusick, 1988, p939). Furthermore, as previously identified in the literature it has also been highlighted that many therapists are unprepared to deal with sexuality, but particularly gay and lesbian issues (Murphy, 1991; Bahr, Brish & Croteau, 2000). It appeared although having received supervision, these participants felt they still lacked space. The difficulty in which it appeared some of the participants in this study had with addressing taboo subjects and addressing the 'Elephant in the Room', might indicate that this needs to be explored

further in UK therapeutic training programmes. It was Hammer (2005) who identified that it is vital that within Counselling services, issues around stigma and disclosure are at the forefront.

Although it can be seen that there was a great deal of anxiety and discomfort from participants, particularly at the start of the process, the subordinate themes 'A Sense of Responsibility' and 'Lasting Impact' appear to develop up on the research of Britton, Cimini & Rak, (1999a). Here it was found that following training on counselling individuals with a HIV diagnosis, practitioners demonstrated an increased commitment to the field of HIV/AIDS, as seen in their desire to volunteer (Britton, Cimini & Rak, 1999a). Both the mentioned themes here suggest that, despite an ambiguity or uncertainty about undertaking this therapeutic placement with this community, as a result of the work practitioners developed a strong and lasting sense of attachment to both their clients and the cause. This could be suggested to be particularly impactful, when considering participants apparent experience of "courtesy stigma" (Goffman, 1963, p32), as early described. Demonstrated in Grace and Margaret's experience of increased judgment and questioning when informing friends, family and colleagues of the work they were about to undertake, which they did not let stop them, unlike hypothesised by Omoto, Snyder & Crain, (1998b).

Other common themes identified as experienced by practitioners working with this client group were; a sense of incompetence and lacking enough or the correct experience in order feel able to work with this group, fears surrounding casual transmission and an intense emotional responses to the work due to the topics under discussion (Britton, Cimini & Rak, 1999a). Thinking back to my experience, as outlined in my reflexive statement, I was again surprised that no practitioners referred to any irrational fears surrounding casual transmission from this client group. I was again

left wondering whether this was not experienced by these psychological practitioners or whether they were reluctant to disclose this to me, as researcher and 'expert', for fear of being judged themselves. Margaret did however offer an explanation for her choice to actively shake the hands of her clients from this population, which appeared similar to that of the research of (Pinson, 2002). In this qualitative study of five Psychoanalysts attitudes towards touching their clients, it was found that the practitioner's decision to make physical contact with their clients was based on whether they perceived it to meet the client's needs. It was specifically identified in that study that practitioners rationalized this decision if they believed it offered the client acceptance and, or containment. For Margaret, shaking her client's hand, meant telling them they were okay and that she felt comfortable with them.

4.4. Clinical Implications

As highlighted in the earlier literature, a diagnosis of HIV/AIDS can have a plethora of physical, emotional, mental, psycho-social, financial and occupational implications for an individual and those around them. The aim of this research was primarily to shed light on the experience of trainee and newly qualified psychological practitioners working with this client group for the first time within the UK. The hope of this was to contribute to an increased awareness around the work in this field for the profession of Counselling Psychology, which appears especially important due to the changes that have occurred over the years and the limited research which has taken place to reflect that. From this research this could be suggested as furthermore pertinent, as these practitioners appeared to enter this world feeling unprepared, holding limited knowledge on the

subject of HIV/AIDS and as having little previous opportunity to reflect on their position to this population and the topics that emerged as important to their experience.

This research could potentially not only inform and better prepare current and future trainee Counselling Psychologist looking to work in this field, but also their educators and supervisors, specifically on Counselling Psychology programmes in the UK but also on other therapeutic training programmes. It was Richelle, Heard & Yurcisin, (2018b, p170) who described that 'infusing HIV/AIDS throughout the curriculum' would be beneficial. This education could extend further than just HIV/AIDS and converging topics, but also the way illness more generally is approached and taught on courses. Furthermore, these findings could be utilised by the HIV/AIDS specific support charities themselves, in order to help better support, guide and supervise their new and existing practitioners in their therapeutic work and what they could expect, which ultimately could provide a better therapeutic serve for their clients.

4.5. Limitations of Project

On reflection of this research and its processes, a number of limitations can be identified. The first of which can be suggested to be concerned with the homogeneity of the sample group of this study. Of the final six participants who were re-recruited by means of purposive sampling, only one identified as a homosexual male and the remaining five identified as heterosexual women, of whom over half were White British. Research has found that this population is less likely to be affected by HIV/ AIDS than any other (Hess, Hu, Lansky, Mermin, & Hall, 2017), which may result in a difference experience of beginning work with this client group, when compared to the

experience of someone in a population group at higher risk of being affected by the disease. As highlighted in (Richelle, Heard & Yurcisin, 2018b), participant demographics have been suggested to affect knowledge, understanding and the implications of HIV/AIDS. One participant, Margaret, even explicitly acknowledged during her interview that she believed her experience and understanding of this work would likely be different to that of a homosexual, male practitioner working in the same setting. Furthermore, participants of this study were not asked to specifically disclose whether they themselves had a diagnosis of HIV/AIDS or not. Although during interview all participants did disclosed their seropositive status, it could be suggested that this difference in participant's demographics could have impacted the homogeneity of the sample.

A further possible limitation related to homogeneity of the sample was identified on review of the completed participant interviews. These narratives indicated that some participants had worked exclusively with HIV positive, gay men, during their time in their placement, whereas, others had experienced therapeutic interactions with a range of client's, including heterosexual women and women from ethnic minorities resulting in possible difference of experience. Another additional possible limitation of this research was that it did not specify which stage of the disease clients had been at, at the time of the therapeutic work; whether they be newly diagnosed with HIV or had been living with it for a while, or developed AIDS. It became apparent that some participant practitioners had experience with all types of client, and some only with one or some. Although these variations are true reflections of these participants experience of working in this field, it could be suggested that these issues could have had an impact the outcome of their experience and understanding of the work.

Although the sample of trainee and newly qualified therapeutic practitioners was chosen in order to access the experience of this phenomenon as close as possible to the event in order to aid recall, as discussed in the 'Procedures', it could be suggested that participant experience and understanding of this work was affected by their limited therapeutic knowledge and previous counselling experience. As for two participants, their work within their specific HIV/AIDS counselling service was their first ever placement and so it is possible that anxieties and other struggles faced by them were not entirely unique to work with this population and as a result of starting any new counselling placement for the first time in their career (Kumary & Baker, (2006).

4.6. Recommendations for Further Research

Throughout this research process I have continued to be inspired and interested by this field and as a result of the work have further questions about working therapeutically with this client group, a few of which will now be identified.

Firstly, as this research focuses on the experience of trainee and newly qualified psychological practitioners working for the first time in the UK, with clients diagnosed with HIV/AIDS, it would be interesting to also explore what this experience is like for the clients themselves. How did they perceive and understand their experience of the therapeutic work and experience?

This research focuses on the experiences of practitioners working with adults with HIV/AIDS, however as identified in the literature review, there continues to be an increase in the number of people living longer with the disease, resulting in a multitude of financial, physical, emotional and

mental health difficulties to potentially arise. As identified in the 'Limitations', this research did not specify at what age or stage of the disease that practitioners would have worked with clients at. Therefore, I believe there would be value in exploring the experience of practitioners working specifically with older adults who have been living with AIDS for a number of years, in order to better inform this endeavour.

An additional area that I have identified as fruitful for additional research include; a continued exploration into the experience of qualified, more established therapeutic practitioners working in this field for the first time. As addressed in the earlier limitations, it was suggested by some of the participants of this research that elements of their experiences such as their anxiety levels and understanding of the works may have been as a result of their limited exposure to counselling practice in general and not entirely as a result of working with this specific population.

A final an interesting avenue for future research includes a qualitative exploration of the experiences of therapeutic practitioners working for the first time with this population, having not chosen to work in the field. As the practitioners in this research volunteered to undertake their counselling placement with this population, it could be suggested that elements of their experience, such as their comfort and preparedness to work with PLWHA, would be different to that of a practitioners who unexpectedly encountered client with a HIV/AIDS diagnosis when working in a general counselling service.

4.7. Conclusion

My primary aim for this research was to provide Counselling Psychologists, both already in practice with this client group or who were considering this avenue of work, a richer more in depth understanding of what this experience may be like for them. Furthermore if this research can promote awareness on this topic or initiate a spark of interest around working with this community, I would consider it a success. I also hope that this research can be used to help better inform therapeutic training centres and supervisors working with trainees within this field as to the difficulties and successes that they may face. I suggest that with the implementation of the above, more confident and competent practitioners within this field could develop, thus potentially providing a better therapeutic environment for PLWHA seeking mental health support.

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Appendix A

Ethical Approval Form

Ethics Application Ref: PSYC 14/ 150
Jan Harrison
Thu 18/12/2014 15:13
To:Felicity Kate Ludford (Research Student) <ludfordf@roehampton.ac.uk>;
Cc:Lance Slade <L.Slade@roehampton.ac.uk>; Gella Richards <g.richards@roehampton.ac.uk>;
Dear Felicity,

Ethics Application Applicant: Felicity Ludford Title: The Experience of Counsellors as they Begin Working with Clients Diagnosed with HIV/ AIDS within the UK Reference: PSYC 14/ 150 Department: Psychology

Many thanks for your response and the amended documents. Under the procedures agreed by the University Ethics Committee I am pleased to advise you that your Department has confirmed that all conditions for approval of this project have now been met. We do not require anything further in relation to this application.

Please note that on a standalone page or appendix the following phrase should be included in your thesis:

The research for this project was submitted for ethics consideration under the reference PSYC 14/ 150 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 18.12.14.

Please advise us if there are any changes to the research during the life of the project. Minor changes can be advised using the Minor Amendments Form on the Ethics Website, but substantial changes may require a new application to be submitted.

Many thanks,

Jan

Jan Harrison Ethics Officer, Research Office, Department of Academic Enhancement University of Roehampton | London | SW15 5PJ
jan.harrison@roehampton.ac.uk| www.roehampton.ac.uk Tel: +44 (0) 20 8392 5785 Follow us on Twi er | Find us on Facebook Join our circle on Google+ | Connect via LinkedIn

Appendix B

Recruitment Email

To Whom it may concern,

I am a Trainee Counselling Psychologist on the doctoral programme at Roehampton University. My doctoral research is looking at the experience of Counsellors, Psychotherapists and Counselling Psychologists who have worked with clients that have been diagnosed with HIV/ AIDS. This project has been approved under the procedures of the University of Roehampton's Ethics Committee.

I am looking to recruit to 8-10, trainee and newly qualified (within the last 2 years) UK trained Counsellors, Psychotherapists and Counselling Psychologists, who have experienced working with this client group for the first time within a HIV/ AIS charity or organisation. Participants would be required to undertake a 60 minute (approx), audio recorded interview, exploring their experience of this work.

If your organisation is able to assist me in this research by displaying the attached poster or forwarding it to your counselling team, it would be greatly appreciated. If you have any questions or would like to discuss anything further, please don't hesitate to contact me on the email address below.

Thank you in advance for your time and help.

Yours Sincerely

Felicity Ludford
Trainee Counselling Psychologist

Contact Details:

Researcher Contact Details:

Felicity Ludford
Trainee Counselling Psychologist
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue

London
SW15 4JD
ludfordf@roehampton.ac.uk

Director of Studies Contact Details:

Dr. Gella Richards
University of Roehampton
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
g.richards@roehampton.ac.uk
+44 (0)20 8392 3609

Head of Department Contact Details:

Dr. Diane Bray
University of Roehampton
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
d.bray@roehampton.ac.uk
+44 (0)20 8392 3627

Appendix C

Recruitment Poster

Participants Needed

Title of Research Project: The Experience of Counsellors as they Begin Working with Clients Diagnosed with HIV/ AIDS within the UK.

Brief Description of Research Project: This research is looking at the experience of trainee and newly qualified Counsellors working for the first time with clients diagnosed with HIV/AIDS within the UK.

If you are a Counsellor, Psychotherapist or Counselling Psychologist that is currently in training or has qualified within the UK in the last two years and has worked therapeutically for the first time with a client/s diagnosed with HIV or AIDS within an HIV/AIDS charity or organisation, I would like to hear from you.

Between 8 and 10 participants are needed to undertake a semi structured interview that will last approximately 60 minutes. The interview will be audio recorded and will take place within a quiet room within Whitelands college or at a location convenient to you. Following the interview you will be reimbursed with £10 gift voucher of their choosing.

Participant Information:

Information you provided by participants will be treated in confidence by the investigator and their identity protected in the publication of any findings. Confidentiality will only be broken if the information shared by participants suggests there to be a serious risk of harm to self or others and that the researcher wherever possible would discuss this with me beforehand.
Participants are free to withdraw at any point from the research without need for reason, however data may still be used in an aggregate form. Interview data will be stored and held securely for a period of ten years after which it will be destroyed.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies). However, if you would like to contact an independent party please contact the Head of Department.

Investigator Contact Details:

Felicity Ludford
University of Roehampton
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
ludfordf@roehampton.ac.uk

Director of Studies Contact Details: Head of Department Contact Details:

Dr. Gella Richards
University of Roehampton
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
g.richards@roehampton.ac.uk
+44 (0)20 8392 3609

Dr. Diane Bray
University of Roehampton
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
d.bray@roehampton.ac.uk
+44 (0)20 8392 3627

Appendix D

Participant Consent Form

PARTICIPANT CONSENT FORM

Participant ID Number: 001

Title of Research Project: The Experience of Counsellors as they Begin Working with Clients Diagnosed with HIV/ AIDS within the UK.

Brief Description of Research Project: This research is looking at the experience of trainee and newly qualified Counsellors working for the first time with clients diagnosed with HIV/AIDS within the UK.

Between 8 and 10 Counsellor, Psychotherapist and Counselling Psychologist that are currently in training or who have qualified within the UK in the last two years, that have worked therapeutically for the first time with a client/s diagnosed with HIV or AIDS within an HIV/ AIDS charity or organisation during this time, are required. Participants will be recruited and individually interviewed through a semi structured interviewing process that will last approximately 60 minutes.

These interviews will be audio recorded and will take place within a quiet allocated room within Whitelands college or at a location convenient for participant e.g at their private practice or at the HIV/AIDS counselling charity where they practice. Following the interview participants will be reimbursed with £10 gift voucher of their choosing.

Investigator Contact Details:

Felicity Ludford
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
ludfordf@roehampton.ac.uk

Participant Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point without reason by emailing the researcher stating that I would like to withdraw, referencing the ID number that appears on my Debriefing Form. If I do withdraw I understand that my data may still be used in an aggregate form. I understand that my interview data will be stored and held securely for a period of ten years after which it will be destroyed.

I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings. I understand that confidentiality will only be broken if the information I shared suggests there to be a serious risk of harm to self or others and that the researcher wherever possible would discuss this with me beforehand.
I understand that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

Name …….

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies). However, if you would like to contact an independent party please contact the Head of Department.

Director of Studies Contact Details:

Dr. Gella Richards
University of Roehampton
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
g.richards@roehampton.ac.uk
+44 (0)20 8392 3609

Head of Department Contact Details:

Dr. Diane Bray
University of Roehampton
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
d.bray@roehampton.ac.uk
+44 (0)20 8392 3627

Appendix E

Demographic Questionnaire

Demographic Questionnaire

Participant ID Number: 001

Age:……

Gender: ……..

Ethnicity:…….

Sexuality:……

Theoretical Orientation:…….…….

Professional Body:……...….

Training Level (please circle): In training (Year: 1 2 3)

Newly Qualified (Within last: 1 2 years)

I confirm that my counselling training took place within the UK.

Yes No

Have you received any HIV/AIDS training from your education course prior to working with this client group.

Yes No

HIV/ AIDS Charity/ Organisation that you worked with this client group:

……..

Have you experienced a bereavement as a result of HIV/ AIDS in the last 2 years?

Yes No

If you would prefer not to answer any of these questions, please leave them blank.

Appendix F

Debriefing Form

DEBRIEFING FORM

Participant ID Number: 001

Title of Research Project: The Experience of Counsellors as they Begin Working with Clients Diagnosed with HIV/ AIDS within the UK.

Brief Description of Research Project: This research is looking at the experience of trainee and newly qualified Counsellors working for the first time with clients diagnosed with HIV/AIDS within the UK.

This piece of research will enable an analysis of the phenomenological experience of this endeavour, highlighting any areas for improvement both in training, supervision and within counselling services, specific to HIV/ AIDS or not, where counselling is offered.

Between 8 and 10 Counsellor, Psychotherapist and Counselling Psychologist that are currently in training or who have qualified within the UK in the last two years, that have worked therapeutically for the first time with a client/s diagnosed with HIV or AIDS within an HIV/ AIDS charity or organisation during this time, are required. Participants will be recruited and individually interviewed through a semi structured interviewing process that will last approximately 60 minutes.

These interviews will be audio recorded and will take place within a quiet allocated room within Whitelands college or at a location convenient for participant e.g at their private practice or at the HIV/AIDS counselling charity where they practice. Following the interview participants will be reimbursed with £10 gift voucher of their choosing.

Please tick if you would like to receive a copy of the interview transcript so that you may read it and make any amendments.

Investigator Contact Details:

Felicity Ludford
Department of Psychology
Whitelands College
Holybourne Avenue

London
SW15 4JD
ludfordf@roehampton.ac.uk

Participant Consent Statement Reminder:

I have agreed to take part in this research. I am aware that I am free to withdraw my interview data from this research at any point without reason, by emailing the researcher stating that I would like to withdraw, referencing the ID number that appears on my 'Debriefing Form'. If I do withdraw my interview data I understand that it may still be used in an aggregate form. I understand that my interview data will be stored and held securely for a period of ten years after which it will be destroyed.

I understand that the information I have provided will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings. I understand that confidentiality would have only be broken if the information I shared suggested there to be a serious risk of harm to myself or others and that the researcher wherever possible would have discussed this with me beforehand.

I understand that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

If you feel any emotional discomfort having participated in the interview, the researcher will supply you with the contact details of the Samaritans, support groups (see below) or advise you to contact your personal therapist if available or your GP.

Samaritans - 08457 90 90 90
Positive Nation - 0207 001 075

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies). However, if you would like to contact an independent party please contact the Head of Department.

Director of Studies Contact Details: Head of Department Contact Details:

Dr. Gella Richards
University of Roehampton
Department of Psychology
Whitelands College

Dr. Diane Bray
University of Roehampton
Department of Psychology
Whitelands College

Holybourne Avenue
London
SW15 4JD
g.richards@roehampton.ac.uk
+44 (0)20 8392 3609

Holybourne Avenue
London
SW15 4JD
d.bray@roehampton.ac.uk
+44 (0)20 8392 3627

Appendix G

Interview Schedule

1.What prompted you to undertake a placement/ start working within this organisation/ charity?

2.What was your knowledge and experience of HIV/AIDS prior to starting work with this client group (if at all)?

3. Could you tell me about any expectations you had going into the work (if at all)?

4. Can you remember your first (then next) experience of working therapeutically with this client group - could you tell me about that experience?

5. What impact, did the HIV/AIDS diagnosis have on you (if at all)?

6. Were there any particular challenges/ difficulties you faced during the work (if any) and how did you manage them?

7. Did you notice any changes in the way you felt as the work progressed?

Prompts

Do you have an example of that, that you can remember? Could you tell me about that?
You mentioned earlier about…
Were there any similarities and differences between those experiences?
Can you tell me a little more about that?
What was that like for you?
Would you be able to speak more about that?
What kind of emotions did you feel?
How did that make you feel?
What was that like?

Appendix H

Annotated Transcript Pages for Jonathan

007

- Descriptive Comments
- Linguistic Comments
- Conceptual Comments

Exploratory Comments	Original Transcript	Emerging Themes
	1. What made you come forward to participate in the research today?	an absence of info/lit/train
TOO FEW? under researched, there is a need unspoken about focus on client?	2. I think it's an under researched topic. There are, I think your project was like the	
	3. second project that I came across asking the question, working with HIV from the	
reference to training & PhD research	4. perspective of the counsellor, which is an interesting question because we don't, I	
	5. don't even remember it being mentioned in training at all. Uhm and there is	
	6. something in that, so it's I think it's a useful piece of research. And also it's one of	'lack of acknowledgment (emphasis) visability'
	7. my interests as well working with HIV and there is very little out there. That's	
Rationale for doing work	8. written. Apart uhm from stuff that was written in the eighties and early nineties.	
old/dated information	9. That's, you know, sort of takes us back to a different way of understanding AIDS.So	'then & now' - time (significance of time) ⇒ medical advances
depth of new	10. the lit, the literature I guess hasn't caught up. There's nothing in the analytic	
progression	11. literature, very very little in the psychoanalytic uh literature a bit more in the	
	12. humanistic integrative literature but again quite old stuff. A little bit in the existential	'an absence/it was missing
passionate	13. literature, there is in terms of change and you know embodiment but again like it's	
	14. sort of it's there is there is an absence around it. You Know. So that's the reason cos.	
ABSENCE	15. So that's what made me participate. Want to participate.	
	16. And you mention there that.aIn the beginning you don't even recall it being	'effect of medical advances'
Could have asked more probing Q's	**17. mentioned on your.**	
	18. I don't, I don't. I mean I, when I got this this started as a clinical placement for me	
	19. two years ago and when I came here, I came here because I was in a mixed status	
	20. relationship. My partner was HIV positive and uhm that was for m-, and I was	'impact of personal' (sources of learning)
I can talk about the differences	21. training at the time and for me that was an opportunity to think about, about it, but	
life not training	22. uhm in training there was nothing. I mean I remember talking about it in training in	
	23. talking about it as a group uh but it was more through life I got thinking about it than	
different reason to start placement then others.	24. you know training. And I suppose that that did make me wonder because a lot of	

25. these trainings I suppose you would think that they uhm would come from a
26. non-normative point of view and in theory they try to but, think about it HIV, things
27. like HIV uhm and also sexuality are not really talked about that much you know and
28. HIV's kind of is usually connected to sexuality or sexual practices or or different sort
29. of uhm sexualities. And genders, so yeah that was definitely nothing mentioned
30. there.
31. And that that that potential for opportunity.
32. It's lost I think. It's lost in, I don't know if it's because the training's haven't been
33. updated like in the case of the literature or if it's because it's something that's a bit
34. alien as a concept. Uhm, yeah, it's it's interesting. But no there was very little. Very
35. very little.
36. I'm curious what what was it like for you to discuss, to discuss it on the course?
37. When it's not there already?
38. It was quite uhm em- quite empowering, quite liberating uhm with the group was
39. quite intimate so that helped. And uhm it was very soon after my breakup so I s-, I
40. sort of brought it all in the group when uhm to the group when it was still quite
41. recent and I found it very very helpful, very helpful and I also felt that it gave other
42. people an opportunity to think about something that we haven't talked about in the
43. three years of the training. So it was a positive definitely positive experience and I
44. remember there was a lot of interest. Cos I brought it in as part of, part of one of
45. those presentations that we do, like the peer learning presentations. And uhm we
46. went over the the slot the allocated time I remember we were talking about it for an
47. hour and a half in the group. It was really interesting, a lot of sort of thinking about it
48. together which was quite a positive experience for me. Uhm, definitely, definitely
49. positive experience, yeah.
50. Something you said earlier on.
51. Yeah.
52. You said about uh there being an absence of it and there was that wondering.
53. Mm.
54. Wondering why that is? And you said the wo-, you said the word uh maybe
55. because it's alien. Maybe cos it's.
56. Mmhmm. Mmhmm.

HIV is not a 'gay mans' disease'. This story is important to. Do I need to change my title to, expectations etc?

I could have asked more prompting questions

do?

57. Is that your experience of it?

58. There is something in the historical uhm understanding of this virus that has sort of
59. been dissociated from the normal parts of society. Uhm, with for example here, gay
60. men that we see here it's very much about avoiding you if you don't have it. And I
61. think historically that's been the case for me too. Avoiding HIV, avoiding getting it
62. uhm but it's almost, but for for the straight communities very often and even straight
63. clients' that we see here, it has been about, it's up over there somewhere. It's, it's
64. outside of our kind of ways of life. But of course it's not, but I suppose these are the
65. social attitudes and the discourses and it's definitely been my experience as a gay
66. man, growing up that there was a lot more awareness and a lot a more of thinking
67. about avoiding it in the gay communities. Uhm, and you know having said that there
68. is over here something that surprised me when I started working here is that people
69. talked about it a lot less. Than I expected. People talk about things like love and loss
70. and the kinds of things people talk about in therapy uhm and less about HIV.
71. Especially these days uhm again there is that sort of absence or something in that.
72. Uhm to the point where I'll quite often find myself bringing it up, you know with
73. client's to check it out. Uhm, you know and talk about it and see what goes on but
74. uhm I don't know if it's because it's been more normalised now. Or if it's, I don't
75. know what that is. I mean I've always thought there is kind of an absence there with
76. uhm HIV and even if we think in, like thinking about the history of it as well. The
77. fact that it was never identified at least for many many years as a virus you know,
78. there's a lot, there's a lot of absence for sure. You. Hm.
79. But you saying there that uh it would be talked about well it wouldn't be
80. talked about it would, themes like love and loss would be bought in.
81. Mmm. Mmm.
82. But not, not the HIV.
83. Yeah, yeah I found that it's, a lot less of a an issue, for lack of a better word. Than
84. uhm than we might think it is before doing this kind of work. Uhm I found that it's a
85. a lot like a lot more people feel okay about it's, than uhm you know before I spose,
86. historically as well we're very used to or I was very used to the ideas of uhm like
87. I'm thinking 'Angel's of America' and you know other kinds of representations.
88. Uhm of the ideal, e- of the kind of AIDS victim or the HIV tragic kind of person.

past & present
seperate/not connected
NORMAL, UN-INFECTED, RIGHT?
AVOIDANCE
First person to admit to avoiding it. Honest
parallel & connection for him
Getting infected
reference to straight others communities
before & after
• Comparison of self to clients.
Did not discuss it as much
why he thinks like that.
just like normal therapy. this reflects
HIV not talked about even in HIV, therapy.
confusion?
Trying to figure it out, make sense.
unsure
Normalisation of HIV, Social construction of HIV. Medical!
ABSENCE EVERYWHERE
SOMETHING/A change/s occurs! TRANSITIONAL? TRANSFORMATIVE?
Normalisation!
Expectation that it's all about them - us
Not great, but okay!
before & after the work expectation that they would not feel okay with it
In the past/ historically, normalised, used to it

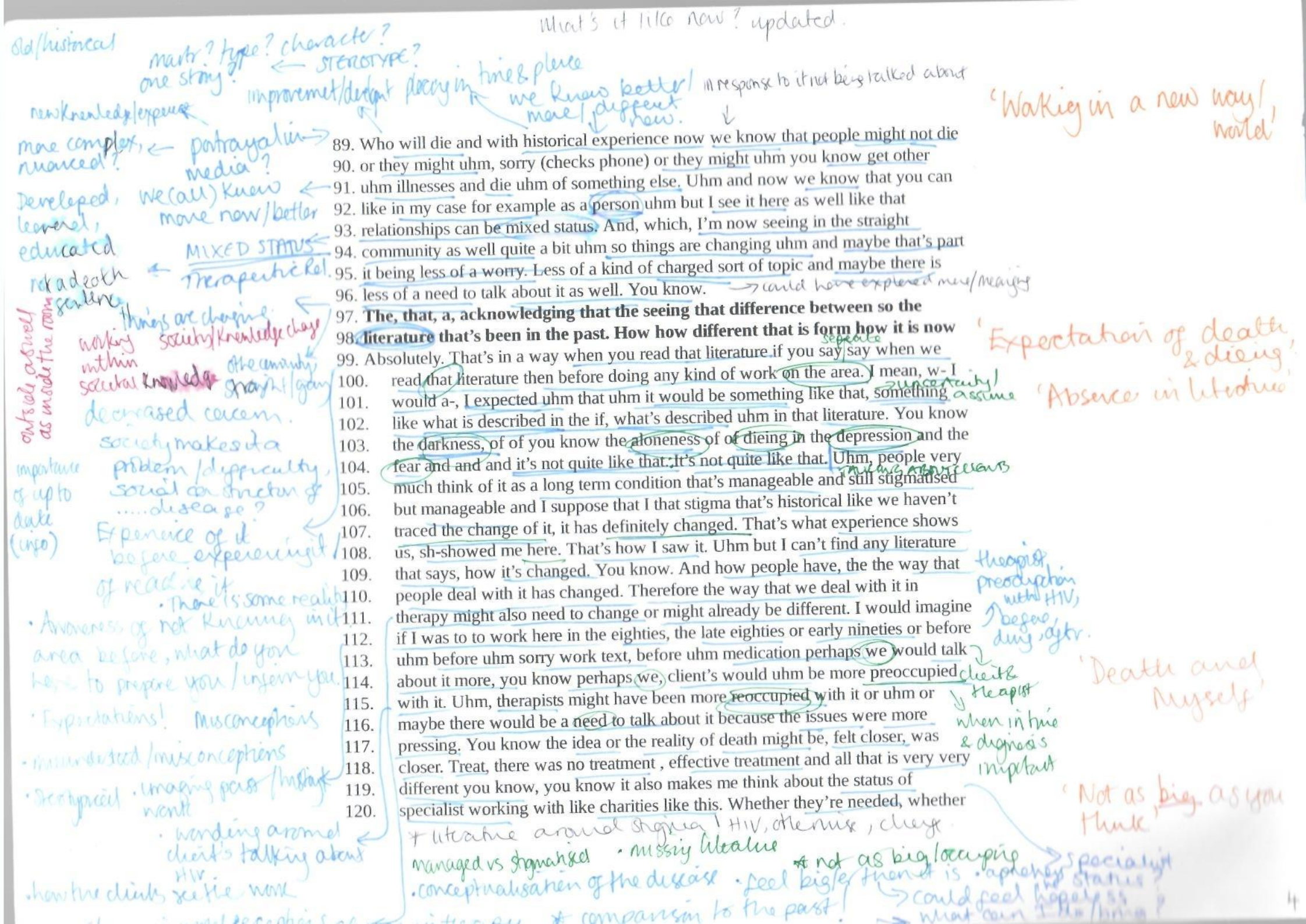
less of an issue

caution? about language use?

What is this?

Known/public knowledge
stereotype
type
social/media representation
neg/bored/helpless reception
reference to film/book?

'significance of relationship then and now - true importance of time & content on work'
'missing/hidden'
'Wakigudy'
'Otherness' 'another world - straight'
'putting self in their shoes'
'working with a new understanding of HIV'
'absence of HIV (therapy)'
'comparison of client to self and other'
'negotiating difference'
'Transformative Experience'
'HIV on the periphery'
'Surprisingly positive'
'Normalisation'
'Media Impact / the importance of time'



89. Who will die and with historical experience now we know that people might not die
90. or they might uhm, sorry (checks phone) or they might uhm you know get other
91. uhm illnesses and die uhm of something else. Uhm and now we know that you can
92. like in my case for example as a person uhm but I see it here as well like that
93. relationships can be mixed status. And, which, I'm now seeing in the straight
94. community as well quite a bit uhm so things are changing uhm and maybe that's part
95. it being less of a worry. Less of a kind of charged sort of topic and maybe there is
96. less of a need to talk about it as well. You know.
97. **The, that, a, acknowledging that the seeing that difference between so the**
98. **literature that's been in the past. How how different that is form how it is now**
99. Absolutely. That's in a way when you read that literature if you say say when we
100. read that literature then before doing any kind of work on the area. I mean, w- I
101. would a-, I expected uhm that uhm it would be something like that, something
102. like what is described in the if, what's described uhm in that literature. You know
103. the darkness, of of you know the aloneness of of dieing in the depression and the
104. fear and and and it's not quite like that. It's not quite like that. Uhm, people very
105. much think of it as a long term condition that's manageable and still stigmatised
106. but manageable and I suppose that I that stigma that's historical like we haven't
107. traced the change of it, it has definitely changed. That's what experience shows
108. us, sh-showed me here. That's how I saw it. Uhm but I can't find any literature
109. that says, how it's changed. You know. And how people have, the the way that
110. people deal with it has changed. Therefore the way that we deal with it in
111. therapy might also need to change or might already be different. I would imagine
112. if I was to to work here in the eighties, the late eighties or early nineties or before
113. uhm before uhm sorry work text, before uhm medication perhaps we would talk
114. about it more, you know perhaps we, client's would uhm be more preoccupied
115. with it. Uhm, therapists might have been more preoccupied with it or uhm or
116. maybe there would be a need to talk about it because the issues were more
117. pressing. You know the idea or the reality of death might be, felt closer, was
118. closer. Treat, there was no treatment , effective treatment and all that is very very
119. different you know, you know it also makes me think about the status of
120. specialist working with like charities like this. Whether they're needed, whether

this kind of work could be done by a GP surgery but having said that, that might might also be counterproductive if if there is you know if it's normalised in that way, you know if if there isn't an increased awareness of it in a context like this. Why then because the normative aspects of sexuality, gender and HIV itself, which I suppose is very much socially constructed to an extent would would be un, would go unchecked, so I don't know that that would be useful either.

It's that.

Yeah. It's like, I suppose, it's right I mean the Tory government they for example wouldn't want to fund specialist projects they might, the argument is this kind of work can be done in mainstream services in the NHS or uhm you as a part of their outpatient clinics in the NHS like you get six sessions or whatever, of what they might call generic counselling uhm but uhm in these contexts there's even less of an awareness of you know of of uhm of issues of of of uhm sexuality, of issues of sexuality but like different configurations of it and uhm HIV as well so depends what we want want I guess in the profession because that might lead to to the work being even m-, I don't know even more, even less effective I suppose with this client group. People might feel less you know uhm sort of acknowledged or or uhm listened to. A lot of people that come hear say that the fact that they know that it's a LGBT, mainly an LGBT charity uhm like dealing with HIV makes it a lot easier to access that kind of support because they feel less judged or less scared of of you know disclosing or talking about it which which is an irony because (laughs) the ex the experience is that people don't talk about it that much uhm but in their words I spose there is something enabling about about this kind of service. Yeah.

That enabling, that opening the doors.

It's already open, I sp I I guess that's what it is. You know they feel that there is somewhere to go. About this. And in fact I don't know if a, if that would make it less on a issue to talk about because here, you know, is present in in in the sort of the way that we work, in, it's everywhere. Like you can see the leaflets there, so in a way it's already here. And perhaps it doesn't need to be disclosed in the same way, I don't know.

No but that.

general, more mainstream less hidden away sectioned off.

thinking around it. to and fro, what is best context

Where is the best place for this work? In view or not. questioning the work. needs Maybe needs to be checked specialist area, one it space because it is 'other' HIV normalised good or bad

• Rational for specialist work, think out loud?

the work in the wider context

AND RELATED ISSUE - SEX & GENDER.

AWARENESS OF THE ISSUE IS IMPORTANT!

TOING & FROING!

Effectiveness of general cohort

• HAS THE WORK NOT BEEN EFFECTIVE

• wondering what's best for the client, their wants/needs

• wondering about the work/ patterns

grasp

Preration! Keeping them & others "safe" free of HIV.

disclosed not in being here.

HIV in the room, working in specific services/ context/ ethos!

it's everywhere

present

in the room with us.

barrier removed

'Always present'

'There but not there'

'Elephant in the room?'

Enabling, it's true so they don't need to.

mywords

'What is it about this work that makes it the same / different.

'Trying to find a place for the/this work!' → Locality.

'There is something different about this work'

'We are different'

'LGBT/HIV etc cross section

153. That might be, that might be part of.
154. **That's really interesting. That because it's, it's.**
155. It's present. Yeah.
156. **It's there. Already. It's doesn't.**
157. Yeah. Yeah, yeah. Cos cos what is it when we talk about things, the things that
158. we're talking about in therapy, we we, because they need to be said or disclosed
159. or because there's a a lack of something, the you know we need to use words or
160. whatever but what happens if we already see it or acknowledge it? To begin
161. with. Again I suppose in the case of HIV that might have, it might go either way.
162. It might be that it normalises the experience of being HIV Positive or or even the
163. experience of uhm of being in danger of like, at risk of infection or something or
164. whatever. And then people can talk about it, people can about (?) or can
165. acknowledge it or it might that that normalising it, s- you know, sort of lead to an
166. an avoiding, an avoiding of what talking about it for themselves, cos it's already
167. here. So, it could go either way, if I think back, if I think about my experience of
168. working with clients it has gone uhm it has gone in different ways, this one,
169. some people don't talk about it because it's painful or hated there and uhm you
170. know the, that might similar to what they do outside of therapy with their parents
171. or partner or friends and other people feel that it's okay and that it doesn't really
172. need to be you know atomised or they they don't need, they don't need to feel
173. that it's painful or they don't or you know sort of a topic that needs to be thought
174. about in the therapy and without it being defensive. Is I guess is what I'm trying
175. to say. So it depends, it's very much, like a lot of the things that we do with
176. therapy anyway. I guess you know, it's the experience of the client, but in my
177. experience what's been consistent. Is a like and absence a lack of something,
178. yeah.
179. **So we have talked a bit about that absence and that lack and it, what is it.**
180. Yeah yeah. It's quite elusive.
181. **(Laughs). Yeah yeah. I mean could we think about that more or?**
182. Yeah we can. Cos I said alien and I said absence and lack and I don't really
183. know what it is. Uhm. Well there is the absence of training, there is the absence
184. of talking about it in training, there is the absence of uhm of uhm the kind of the

Why do people come to HIV therapy is its not what they want to talk about.... they are treated as normal there that Otherness is stripped away?

let out or in

It's already there/present!

trying to make sense,

not spoken about

please say I asked about this

there is something about the context.

asked more what it's like for them! Interpret from what they're saying.

questioning, what does the therapy do/purpose. NORMALISING?

their experience!
→ positive
→ danger
→ risk of infection

one way or the other, extremes? not one way, complex - different.

to normalise or

Keep seperate

Reasons for not talking about it.
- Parallel.
- don't talk because it painful or okay.
- Talking about what their experience was like. (client)

Says it for the good or bad, don't have to acknowledge it consistancy is the absence.

the client.

at core

'Rationalising absence as avoidance'

ABSENCE

What it's like for them.

This has been said before

'Absence'

talking about it

training

how is has changed!

literature

185. the changes that have happened haven't been acknowledged in the literature and
186. in society, some parts of society they haven't, so there is that stuff, but what is it
187. about that absence, why am I sort of talking about it in these terms, I don't know
188. uhm.
189. Maybe we don't know right now.
190. Yeah, I suppose we don't, I don't. Yeah.
191. **Uhm, really really interesting. There was uhm, earlier on you said about if**
192. **had of worked in in the eighties uhm I suppose. With the knowledge of the**
193. **literature that we have from the eighties uhhh. You said about I might have**
194. **a expec- expectation for the work to be about this or about this. Darkness.**
195. **Did you, did you have any expectations coming to the work? If at all?**
196. I did, I thought it would be a little harder than it actually is. I thought it would be
197. a lot more uhm complicated, dramatic for lack of a better term. Than it actually is
198. and uh I imagined uhm a lot of death and suffering and uhm pain you know in
199. relation to HIV and AIDS. And there was a lot less of that. In in the two years
200. here very few clients uhm have AIDS you know. They they like their their their
201. viral l-, most of the clients, most of the clients it might be undetectable or in
202. treatment of whatever. So very very few clients are dieing or they're seriously ill
203. and uhm or have partners or are seriously ill and uhm. I suppose that makes it
204. easier. Mm and that might also make it less on an issue. At the same time.
205. Make it less of an issue. Because.
206. Because it is less connected to death and dying and perhaps less than it used to
207. be. And definitely less than I expected.
208. Definitely less.
209. Mmhmm. Change, uhm comes up a lot, change more than dying.
210. Change.
211. Is what I'm trying to say, like changing, feeling different. You know thinking
212. about uhm relationships and situations in a different way uhm that's what comes
213. up a lot. People say a lot uhm from now on I'll, you know there's that. There's
214. something, there's the before and after infection or diagnosis. Quite a bit. When
215. we talk about it there is a lot of that or people often say that that's before I was
216. diagnosed, there's something in that. Yeah. Uhm it's kind of a significant uhm

Society

Expectations

Gay man with HIV partner/ex)

- harder
- complicated
- dramatic
- death
- suffering
- pain
- AIDS

Wondering about the work, unknown

less & more of an issue.

Going into it! The reality of it is different!

talking/referencing medical terminology

- It is less serious so it presents as less serious?
- stage of illness relevant.
- not facing death, health/illness aspect managed.
- before & after the diagnosis
- time, from now, marker, stamp!

'Expecting challenges'
'About death'
'Then and now'
'Old knowledge'
'Impact of medical advances'
'Impact of stage or work (diagnosis)'
'Importance/impact of time - then & now'

point in time. Yeah.

Separation between.

Yeah it. It's a point of reference yeah, point of reference. I don't know exactly what it refers to. But my sense if it's about change. It's talked about as a change. Things changed. You know, 'When I got diagnosed or after. Uhm, I'm thinking about and that change might be positive, very often that change is positive, I'm thinking about a client of mine who was talking about it in terms of of uhm becoming a lot more social and getting out of themselves and. Having less to lose and being less afraid and you know they change in perspective I suppose. Yeah. Mm. And again that brings me back to what I'm saying about the the perspective that we take in the literature.

Hm. That thinking about client's. Could I, could I ask you to. If you can remember. You first, your first clients here, when you first started working here. Can I, can I ask you to, well if you can talk about an example of it or, or just start talking about that? That when you started working with a client.

Yes. I felt, sort of thrown into something. And having to find my own way of doing it. Uhm, there is no manual, there is no, there is training that we get here. But in my case as well I started working before getting that training. So it was a couple of months I think if I remember correctly. But uhm, I remember that feeling of okay, what is the, what is the issue here? What is the, what what are we dealing with? If anything different. Uhm, and that's one of the first things that surprised me, the fact that people talked about it less. People don't come in and say, 'I want to talk about my HIV', people come in and say, or they did anyway, I remember quite clearly, I want to talk about my partner or I have an, I'm in an abusive relationship. Or, uhm I uhm take drugs or uhm I don't know what I want to do in life. Or I've got problems at work or. You know, I've got problems with my parents or you know, thing s that, things that might be seen as uhm more usual I spose. Yeah, than uhm 'I got HIV'. With client's that have, are just diagnosed, that's interesting, I found very hard to, in the beginning to, I found it harder to work with clients that were newly diagnosed. Uhm because I spose, mm, there is, there is also the idea you know, mm, a lot of the client's that are

newly diagnosed I think they might not come because they want to be in therapy. But as a, as a part of dealing with that initial sort of you know, might feel a bit thrown, cos they just got diagnosed. What do I do about, you know trying to find support wherever they can. Which gives, it gives it a different focus cos there there is that sort of initial shock of change and 'Okay, what's changed? You know there is that, like what is it that's actually changed, I feel a load of people say, I feel healthy, I can't you know, see it. There's nothing. I don't feel, people say, some people said, I remember, I feel dirty or I feel uhm uhm depressed or I feel th- there is something wrong but it was quite uhm more of like a state of mind. I guess. You know. And people say very often I, but I don't feel ill. I know that I'm ill but I don't feel ill. And that's quite difficult to you know. To integrate uhm with newly diagnosed client's. What's am I going to do from now on how will I you know. The change hasn't happened yet, like how am I going to have sex. What kind of sex do I want to have uhm other people say, it's okay because everybody has it. That's the other side of that kind of normalisation of it I think. They you know other people say, a lot of people actually say that which is is is, it would be useful to think about that and the consequences of that. If we say everybody has it. Then what does that mean about protecting ourselves or you know having protected sex or iiit, that I guess that, that might be that risk of dismissing. Dismissing it all together, uhm, in terms of of urm prevention. Uhm, in the last I'd say year, I've seen a lot more clients' all my client's at the moment and I has been like this for a while are dealing with Chem Sex and HI, sex and drugs and HIV. And ag- having acquired HIV through injecting mainly crystal meth. Or having bareback with other men, and that's an interesting th-, that's an interesting sort of phenomena at the moment that's happening. The the the the sort of the drugs the addictive aspects of of that sort of whatever that is, there's there's a lot more usual these days. For some reason there might be an increase in people that use drugs as a way to feel sexual or desirable in my, well. There's a lot about the apps, the online apps and online communities and sex parties that are a lot easier to to find and to organise. It's a lot easier to meet people I suppose on Grinder or Tinder these days. Uhm yeah and and and especially in the gay community there is a lot

about Crystal Meth and HIV. Injecting and sharing needles And you know the consequences of that. Yeah.

I'm curious. You, do you, do you feel do you notice a difference in the work between people who have contracted through injecting or through sex or , d- do you notice a difference? I suppose.

Quite often people don't know. Uhm and that's different to that's difficult to talk about because there's nobody to blame and there there isn't a narrative like I got it in this way. You know there is no narrative so it's it's a lot more about having it, coming to terms. With that. When there's a n-,when there's you know, when there's when somebody once the people know for example, have had it for a whole and they know they got it in a relationship or through somebody else and they didn't know that the other person was HIV positive or the other person didn't know either that they were uhm there is a lot more relational sort of stuff that's talked about there. Like how do they feel about that person. Uhm, s-sometimes there's anger, there's hatred you know forgiveness there's a lot on that. Whereas when people uhm get it through like injecting Crystal Meth or sex parties or whatever there is guilt, qu- you know people talk about, people think a lot about (sigh) w- w-you know 'Why did I do that? You know why did I, you know, uhm and it's it's a lot more to do with difficult feelings that people can't you know pr-, you know process in a different way. Usually we get to the the addictive stuff with that like the a the having to numb difficult feelings whereas through drugs or sex or that kind of acting out if we you know want to call it that, whereas in in cases where it's part of a relationship. Or you know an old relationship or you know through somebody else that's in my experience there is a lot less of of that kind of difficulty with feelings and the need to act out to manage these feelings whatever they are feelings of loneliness and rejection usually. You know uhm or loss, feelings of loss uhm people usually feel b- like bored or lonely. And then they go to a sex party uhm you know then there's the other side of it that having people that have had it for a while. That have been HIV positive for a while, f-, that have felt that's happened a few times here in terms of my client's that they've they feel that they've got nothing to lose now. And they're not afraid anymore and therefore they can go out and have

what was his experience/ What did he fear

difference in risk between unprotected sex & drug/inj rate. (complex/multi faceted)

unprotected sex uhm with other men that have it and that that's you know, what do I have lose kind if thing. A lot of people feel let paradoxically less scared because that fear of getting it stops. If that makes sense. Like there is, people are not afraid anymore because they got it. So they don't need to be afraid of getting it. That avoiding it and not getting it. Am I going to get it? Do I need to go and get tested? You know. So that that ends and then I suppose sometimes with that people are forced back into themselves to think about what they want to do. And how they want to go about it. You know. Whereas in the case if drug, a lot of drug use and getting it through injecting and inse, you know habitual drug users there is a lot less of that talking and thinking about what they want to do and uhm how and life and. This such, the more symbolic stuff and there is a lot more about feelings and the body and you know in a way more basic things. You know how am I feeling right now? 'I don't know' people say. You know, quite often. People that uhm use drugs uhm so we-, it's almost like we start with something more basic. You know, I spose. But I don't know there's an intrinsic link other than the fact that the drug use increases the the chances of getting HIV or others. You know, diseases. Uhm, I don't think there is an intrinsic link. Yeah. Other than that.

Okay. Something you mention on about, when you first started here. There was that, you had your training a little bit later on or the training that was Given by XXX yeah. Uhm. You said the word kind of thrown in. Mm. Could, could we look that more? Like what, that what that was like for you?

'absence'
'isolation'
'it's one time'
'Missed opportunity'

It was lonely, to it's. I found that it was a bit of a lonely experience, regardless of having supervision and you know. Kind of group supervision as well. Uhm I felt that there was this kind of uhm to, finding my own which I suppose it's, it's always part of it but it was more here. More with this client group. Or more in this organisation. Uhm you know and we, for example in training we do talk about uhm addiction. We talk about personality disorders, we might talk about uhm sexuality a lot less actually. Uhm, but we never talk about, like I said, we never talked about HIV so that, it was part of that experience of being thrown. You know the training here, I spose, I would have like a more comprehensive

comparison to other placement

missing in training

want more, can't learn enough, so much, overwhelming?

* I felt overwhelmed with all the info, I need to pick out.

certainty in training, something to hold on to.

felt alone, lacking, needing support.

wanting/desiring/searching for other people experience, what they feel.

'Importance of awareness/knowledge self tackling'

'theory vs practice'

'Students 'sex'

training on sex wasn't deep enough.

Sex vs theory practical info

thrownness

345. training package here. In the organisation, that takes us through you know, sort
346. of the the kind of topics that are relevant uhm there wasn't much of, much of that
347. at the time and I think it, it would have been useful to have more training. In
348. house about how we've worked with people so far as an organisation. How you
349. know, what has come up? What is the experience that the organisation, the
350. systemic experience that we can talk about and share and. And sort of
351. disseminate. Uhm, there wasn't, there wasn't much of that and I think it would
352. be lot more useful if there was. Yeah. Yeah.
353. **So, just thinking. That you're saying sexuality wasn't covered in in the**
354. **training, you said.** — I focussed too much on training,
355. Well not as much as I, very little about sexuality, uhm, of course the analytic
356. literature talks, the psychoanalytic literature talks about sex in a particular way.
357. And it doesn't really talk about sex, it's about something else but I mean we
358. could argue that it was talked about there. In terms of, of uhm phallic this. And
359. urethral projections or whatever all that stuff but that's not really about sex. Mm.
360. Uhm and the reality of it. And the experience of it. So that aside we had very
361. very little training in you know or discussions about working with uhm gender
362. queer or. Or working with uhm people that are other than Freud's psychic by
363. sexuality. That, people that are bisexual or gay or well there's a lot, there's more
364. but there are things like regulations like the BACP or UKCP regulation. About
365. working with gay clients or refusing therapy or you know working within that
366. sort of anti, anti discrimination. Uhm ethic, there is stuff about that but that that's
367. not in, there was no real engagement with that the ideas. You know what do we,
368. how do we position ourselves in relation to these things how do we see our
369. bodies and our sexuality and. And what you know our our sexual selves, very
370. very little talk about that. How do we have sex? How does sex come into the
371. therapeutic encounter in terms of erotic feelings. Again there was a lot about
372. erotic transference, erotic countertransference the oedipal the pre-oedipal mother
373. or whatever. Again that is not really about sex. It's about something else in that
374. theory, so, in in real terms and in in in sort of terms of what's happening in
375. society there was none, there was nothing. Yeah. There was nothing. Uhm and
376. that's another aspect of of it because I guess that thrownness because in this

what might/could we have felt in this situation?

organisation a lot of clients identify with different sort of, sort of uhm sexual identities and different ways of doing things and there is like a real diversity.In terms of the client group here. Uhm and uhm we, you know, I heard things that I hadn't heard before, different ways of enjoying sex, different erotic fantasies. And I thought there is nothing, none of, none of that is talked about in society or in training. When yooouuu it's, I don't know if it's, I suppose those two would be linked but d-, you know, it's definitely not not taken into account. At least where I did my training at at XXX. XXX it wasn't really talked about or taken into account. Uhm, and I think that's a real real shame. Like a real lack that as practitioners we don't get an opportunity in training to position ourselves in relation to you know these top, these ideas and and the experiences of sexuality and being sexual. Uhm, so that we can uhm you know discuss these these with our clients as well. When they bring these things to therapy. Uhm and I guess the minute we talk about HIV we might talk about how how how did one get HIV so that comes in. You know the the sexuality comes in anyway. They're qu-, they're linked. I spose HIV is a sexually transmitted disease or it's it's mostly seen as that. Even though there are other ways of getting it. Uhm, so it's there. Sexuality is very much part of it whether it's talked about or or you know undisclosed it's there. You know it's in the room. The question of how did you, how did I get this, is there, so, i- so it's very linked. Sexuality not being talked about in training, HIV not being talked about in training or at least the training that I did, uhm sort of sp-, uhm comprehensive and p- training packages that would deal specifically with this. Kind of work. And I'm not saying we need specialists for everything uhm I suppose that's the other, the the danger but uhm in this area I think we need more discussion and more training and more opening it up. For debate again, you know uhm, regardless of where the funding is. You know. And regardless of the b-, and the sort of political aspects of it, yeah. Mm. **Hearing, I guess hearing you you talk about that that like well hearing things that you haven't heard before. Or, getting to, getting that opportunity to position yourself be in the room before you, before you even, instead of before you seen a client I'm really curious what that's like for you, that hear, hearing things that you haven't heard before and**

diversity in client group

new info to him

absence, again societal frame in context, missing not in society not in training.

TRAINING (QUESTIONS OVER IT)

feeling unprepared by training

loss

TOPICS OF SEX & GENDER/SEXUALITY

POSITIONING SELF

OURSELVES FOR CLIENTS

HIV, transmission → linked

How disease is seen?

Talking about sexuality

talking about LGBT (ME!)

missing in training

pos & neg

'putting self in their shoes'

'Looking at own shadow'

'Transformed experience/ Learning'

'About from society/ awareness'

'Let them by education'

'Thinness'

messy

409. **positioning yourself. I suppose those are two separate things. But.**
410. As I go, as I went along.
411. **A yeah, as you went along yeah.**
412. It was quite difficult. It was quite difficult I mean this is a community placement,
413. was when it started a community based placement and before this my placement
414. was in a environment where people might be seen as more, as more unwell.
415. Uhm, having psychiatric diagnosis and I found this placement here more difficult
416. when I started because there is no, there there was less narrative, there was less
417. you know. Sort of even the diagnosis kind of narrative but there was less
418. discourse for me to hold on to. I noticed that like I had to work on myself as I
419. went along on what I thought about these issues, how I saw my my own
420. sexuality how I uhm positioned myself and the fact that I had to do that as I went
421. along. To a a greater degree than n other places. Made it harder work and
422. interesting but harder definitely and and I remember thinking very often that
423. I-like feeling uhm almost like hard one by and tired with it. And feeling uhm
424. w-what am I getting in return? What am I getting for this you know. And that
425. was quite interesting sort of and difficult feeling know. To shake it off feeling it
426. took me a while, it took me a few months to to sh- to to for for that to shift, you
427. know. To shake it off and to yeah, it was it was uhm it was a process. A long
428. process.
429. **A difficult one.** *
430. Yeah yeah, it was it was. It was difficult and kind of lonely and you know. You
431. know. And quite personal, it was quite personal. Not only because I I had been
432. in a mixed status relationship but because I had to think about these things for
433. myself. Not in relation to my ex partner not like, 'Oh I'm thinking about what it
434. is like to be in a relationship with you know'. But in relation to how I saw my
435. myself and what I wanted to to do. How I wanted to have sex. Uhm you know.
436. What did I think about my client's fantasies? And identities? What did I think
437. about client's that were you know might not you know, some clients for example
438. would come and say 'I'm HIV positive, but I don't use condoms with other
439. people' you know 'and I don't tell them'. What did I think about all this? You
440. know uhm, it it it it's uhm and it was quite powerful. I made me think about

* should have asked about shift?

Repetition
university placement requirements
environment comp- and in
psych vs HIV, challenges due to lack/novelty/grab hold of/on to & feel secure/knowledge
self development
more personal exp. than other participants due to sexuality.
going alot ? of self.
difficult/lonely/personal
relationship to self
ethical considerations/ element

'Expecting difficulty'
'Personal, Emotional Impact'
'Drain' 'Questioning value/ impact of work'
'Isolating, the only one'
'Reflection'
'Transformed / Permanently changed'
'Ethical implications'

myself a lot. And my relationships and being gay and gender and w-you know I what it meant to me and whether I uhm and the the the stereotype of the gay man that has HIV. That like I kept thinking about that a lot and what it meant and the fact that especially when I started like the fact that my generation we kind of grew up with this idea that if you're gay you'll get HIV. Don't be gay you know that that stuff. So it was, it was the the very useful kind of rich journey emotionally. Even though I expected it to be as a community placement I expected it to bring less, to bring up less stuff, within within me. Or less of my own feelings then I'm, I was surprised that at the time to find out that it was very much about me as well as a person that was encountering m- aspects of myself in a very real way. Uhm more than working with clients that are HIV positive and therefore we're working with something. That's in bed more with them. And I'm engaging with something that belongs to them. It was a lot less of that than I expected.

I mean hearing you talk about that how how personal. That churning up (laughter), like I don't know.

It's yep, it was it was uh quite powerful. And again it's that you know it's not out there with HIV there is there, is a lot less of that in my experience, that you know and I suppose there is a bit of that in in this, there is a lot of that in this Work. Encountering parts of ourselves, uhm, but for me definitely happened a lot here, a lot more than in other places. Yeah.

And you said uhm it was a a lot more about you. Than you'd expected it to be.

Than I expected to be. Yeah. Definitely.

Okay, thank you (laughter). It's really really interesting. Uhm just to check for a second.

Go ahead.

There was one last, I've got one kind of more concrete question that I would like to ask. But.

Go ahead.

In whilst whilst we were talking you said about finding your way through it. It was 'uhh'. Finding your own way. Could you, could you talk to me a

little bit about that, like that finding your own way in the work?

Yes, I th-, I guess thinking about it now and talking about it with you it was a lot about the fact that I it bought things up for me. So I had to find my way through that and back into the work and you know the where was the focus here and how could I you know focus. Uhm so it was a lot about that, thinking now. But also a lot about like that it was almost like I had discovered that uhm 'a lot has happened since the nineties'. And uhm we don't really know about it that much, we don't talk about, we don't talk about the change. I mean, we don't, we don't talk about things being easier these days perhaps for people that are HIV positive or I didn't know about that. I didn't know about, I knew that there was treatment and medication, I didn't know the specifics of all that? So I, so I kept being surprised. By that sort of information and finding out as I went along and finding out a lot from clients. Client's would say that there is this or that or the other. Or that this is what it is like. You know, these days or whatever. Back then people would say, back then it was like this. Now it's different. Mmm. Uhm and and that surprised me. You know especially with in the first six months that I was here and that I didn't feel that I knew. At all, so, you know there was a lot that was new I suppose and at the same time I came up. So that I guess that's what I'm what it is, what that that is that finding my way way through it. And and learning and part of that was learning that new information.

Mmm. Would that new information keep coming up, that constant surprise?

Yeah, yeah. That's the kind of 'Oh, I didn't know that'. That sort of feeling.

Yeah yeah.

What, that that surprise feeling?

Yeah. It was hopeful. It was it was. It was hopeful because most of the stuff that people talked about was a positive changes or the things. The things that became easier for them like older clients that we get here. That have that historical experience. Of being diagnosed in the early eighties. You know they they say a lot, almost every time, they say they and they would say them too 'I thought I was going to die'. It was you know a lot harder. But now it's okay. You know. It's that, there was that a lot and that surprised me. You know, because I didn't

know about that. Uhm, there was that uhm, that reminds me of that play that came out last year, the the movie. Uhm called uhm ah what was it called? It was about the miner's strike in the gay community uhm in the eighties. Uh, it's British film, Imelda S- S-, erm whatever her name is. I, if you google, you will, you will.

Okay, I'll google it.

But that, in that in that film. Uhm they, what the film is about, it's about the kind of gay support, support by gay people, by the gay movement of the early eighties. Uhm how they supported the the s-mining strike. When Thatcher wanted to kind of close down the mines and everything. And it's a very interesting film. Uhm and something of that hope really that film reminded me of that what client's, what this older client's say that it was difficult but we found a way through all this. Mm. And that that's that was a very hopeful and surprising kind of idea. At the same time.

Hopeful and surprising.

Yeah, yeah, yeah, yeah, yeah. Isn't, it's funny. Cos, when hope is surviving but I guess there was, there was so much. And growing up in the eighties and nineties like the discourses around HIV were so urm u- u-, in a way scary. And um, in many ways they were scary they, like I remember they um, the the the kind of commercials that health agencies. Would would uhm publish and it was horrible stuff. Stuff that uhm, is not around now much in people's experience. Anymore.

So that, that media coverage that. Those those adverts, tombstone adverts, that, it.

Yes, yeah th- they well they, I think they were uhm part of a social construction. Constructing that. That condition. Socially. And projecting a lot into it. Uhm and In fact I you know I I working with client's in different cultures. That are HIV positive and live here, there is, there are some cultural differences. In my experiences there are some changes in how people see it and how their communities and their parents might see it in the country where they're from. In the UK there is generally more openness. At least in terms of having disclosed one's status to their parents or you know communities or there's m-, there is it's it's kinda I guess like a it's it's moved to the outpatient part of hospitals.Anyway

so, it is more visible, uhm but in other parts of the world there is still a lot of fear around that. You know, I can't tell my parents. Because if I do they will die or they you know, hold me, that that again. So it's very similar. In fact, many times I've thought and client's have said as well it's a bit like coming out. The experience of being diagnosed with HIV is the similar to the experience of. Have, going out as gay. You know. And that people very often come to see it as a similar process. And you know, I I think I could see a, a link between how people came out and how they've dealt with their HIV diagnosis, you know. So there might also be something in that.

The-, I want to say correlation between, but the between or or not.

A si, similar uhm. Of how, of how people are disclosing this secret I suppose or. Or when it's a secret or carrying or dealing with it. You know, like I'm I'm gay nd I'm HIV positive becomes a similar situation and I suppose socially, historically it has been, it has been they have been equated but that's not what I'm really talking about in this it's more that people deal with it in similar ways. So the experience of coming out can quite often be really informative. And can can guide people through disclosure as well. You know, what happened back then? How did it go? You've clearly survived it or whatever it is. Mm. So it's it's uhm interesting because not having that experience, not not being out or not coming out makes it a lot harder to. For people to disclose their HIV status as well I think. People that are not out. Because they come from communities that might be more homophobic. Than the mainstream. Uhm or people from other cultures that have not had the opportunity to come out. Find it a lot harder to to talk, find it a lot harder to talk disclose to their com, to be open about it, to work through it and they talk about it more here. Mm. It becomes a lot more of the focus of the work. The fact that they sees themselves as having HIV now and that's kind of that's it. You know. It's it's uhm a bigger part aspect of their identity. You know than other people that have have had a positive experience of coming out. Or if not positive they have worked through this. Yeah. Visibility I mean it's it's it's uhm, like yeah visibility I suppose it's important yeah. It's important. And you know, it goes a long way and that goes back to that idea of that it's not visible in training, it's not there. It it it makes it a lot less pressing you

Coming out comparison Reveal as other

Secret

Dealing with diagnosis & sexuality

Working with disclosure

Not out outside, not out inside

Outside parallels inside. homophobia the work is harder?

how bigger/part of their life/selves it is contingent experience

'Trying to understand the disease'

'outside impact on 'visible'

Visibility

training

'out of site out of mind'?

opposite of what I previously wrote. ←

569. know people that can't talk about it outside the therapy. Talk about it more in
570. therapy. It's that paradox. You know so. Mm.
571. Thinking about I guess your experiences uhm you mentioned before about
572. uh your kind of supervision that you'd have, had group and. Maybe
573. individual as well.
574. Yeah.
575. I didn't know.
576. Here it's group supervision.
577. Here it's group.
578. I also had individual private supervision for a while. I'd go in and out of that
579. (coughs while drinking) when it.
580. You okay (laughter).
581. Went down the wrong way.
582. Oh no (laughter).
583. When in terms of here it's uhm group.
584. Group here.
585. It's two hours a week. Every couple of weeks. Plus, oh, plus half an hour
586. (coughs) individual every month. After the group. So, it's it's comparable to
587. most placements. It isn't more or less. Uhm, mmm.
588. Yeah I think was just thinking of when you when you've come up, come up
589. against things uhm when you you mentioned the the loneliness, the uh,
590. having to try, the figure it out yourself in a number of ways. How, how you
591. managed those, I want to say difficulties, but how you managed those
592. things?

therapy ←
personal ←

593. In therapy. Therapy I found very useful and my therapist at the time was very
594. uhm uhm she knew a lot about sexuality and gender. And uhm could talk about
595. these things in ways that were very enabling and very. Uhm uh uhm therapeutic.
596. (Laughs) for lack of a better term. And I still to this day I really appreciate that.
597. Uhm so therapy was a great very very helpful space for me. Uhm and also
598. supervision. Here. Uhm, the the the kind of the relation, the supervision
599. relationship. That was difficult at the time. Uhm, also because I was working
600. through. Things that had come up for me. Uhm but it worked out and it it we

'Personal Impact'

worked through it. So that was also very helpful in the end and quiet containing in the end. Yeah.

You said it was difficult at the time because of what was being brought up for you in the work.

Not solely but you know very, I find that in supervision there's often or there can Be a a power dynamic or a clash or a disagreement or you know. Uhm I've had experiences of supervision and sometimes you know with the same people that uhm are very helpful and very open and other times experience that less helpful or more oppressive or you know there is power in in the, there is power negotiation and that relationship. And it can go in in and it has gone in different ways. For me. And at the time here I felt that I was locked in a power dynamic with my supervisor. That (adjusting seat) looking back now was great in terms of my own development and learning. At the time I felt. Quite difficult and and uhm uhm just like an an added difficulty. You know. But of course it was part of of all this that was happening. Yeah.

When you were saying that the word that you used earlier on that that 'hard done' by word popped into my head.

Yes. Yes. It was very much, in the context of my supervision that feeling. Yeah it was very very (laughter), you, you are so right. Yeah. Mm. It was definitely in supervision that I felt hard done by. Back then. Yeah. Yeah.

But it is that, y- y- you say now that.

Mmhhm.

It was beneficial, like.

It was.

In terms of learning.

In terms of my own development as a persona and as a practitioner I, things will not always work. I spose is what I'm saying. And that's okay. And it doesn't mean that they need to be fixed. It might mean that we need to think about it in a different way. Or to move on. Or whatever it is. You know. And there was something in that that was quite valuable, uhm, coming to terms with that. Things things don't have to be fixed (laughter). You know. Things don't have to work. All the time (laughter). Yeah. Yeah. And it's a supervision I suppose that

might, why wouldn't that come up in supervision. It being a power structure as well. As you know as a helpful relationship. Uhm, but again therapy quite helped me quite a bit with that at the time. Yeah.

Therapy sounds really, really important, in this.

Therapy is absolutely necessary I think. Uhm, because things do come up. And uhm, they they need to be to be talked about and felt and thought about. And uhm I suppose therapy it, provides more of a space to do that than supervision. Because supervision these day is more rushed. There is less of it around. Uhm. It's a bit more tick boxy perhaps. Than it used to be, I'm assuming. Yeah and less free-er I suppose there's allot more organisational stuff. Uhm, you know, organisations have become more corporate and that comes in, into the supervision and into the work. You know we have to do forms that were, we wouldn't have done. In the past. We uhm have to measure outcomes in particular ways. That's you know, in the past we me-, I I suppose that goes back to the argument of you know (sigh) HIV and funding and funding. HIV counselling (sigh) uhm you know we might measure that by what doing a core form or whatever a psychometric sort of measurement. Or whatever but, how do we measure these things. You know what does it mean when I give my clients a form of that kind to to fill in, twice. Or every sixth session or whatever. Uhm, yeah it's a bit misguided, I think it's it's. It's, we might draw conclusions that are not really sort of experienced by the client, we might, we might get uhm a distorted view of what might. Be going on for clients. For the client group. A lot of people say uhm, client's are not doing better for example, session one. There scores were higher than this, session six or twelve therefore counselling is not working. Or whatever. Or it's not needed. or we, funding is not needed. But that's not what we hear from our client's. You know. It's the opposite that we hear uhm very often so that aside, not that aside but I suppose what I'm saying is that that is now part of the work. And part of the supervision and therefore therapy uhm is less affected by all this. Yeah. I suppose that's what, why I found it more useful. At the time.

You said that that freeness of it. Was it the-

It's that that availability that yeah that freeness and I think both are absolutely

necessary. I can't really imagine being out of therapy for a long time in practicing. You know without being in therapy. For a long time. Yeah and I don't know, I sometimes think about training's that don't have it as a requirement to have at least weekly therapy. Clinical, some clinical psychology trainings. And that's quite uh. Worrying actually. Yeah.

Mm. So incredibly interesting and useful talking to you, uhm so with it's.

You've got one?

It's just twenty to.

If you've got more questions we can.

Oh no it was just that I wanted to urm.

Mmhmm.

Check to see if there was anything you feel that I haven't asked about or there's anything else that you you'd like to say or would want to say? In regards to your experience? There doesn't have to be, but so (laughter).

I've s-, I think I've said a lot, no. I can't quite.

Yeah?

Yeah. I feel okay with it all. Yeah.

That's great. That's great. (Talking about copy of transcript and how many participants I have etc). See that that comes up a lot. Be it, because that's the argument of like counselling in the NHS. Or in a GP surgery. Or you know. Specialist services. Yeah, so ideally I would like to look at both but for the focus of this, I've had to narrow it. Back down. It makes sense.

Yeah it does make sense.

It makes a lot of sense. Otherwise it's a different, encountering, encountering an HIV positive client in in the context of an organisation that doesn't deal specifically with that is a very different thing than working with HIV positive client's. All, you know. All the time. As, as a client group. I think it's very very different. Uhm, cos I suppose I guess it would have to be worked with in a very different way anyway. Because in a generic, uhm generic, in in in a non specialist. Environment, well I remember working in the therapeutic community uhm, it was a forensic Project. And there we got an HIV positive client in that community. It was a personality disorder project. Uhm, in the NHS. And uhm

'Importance of therapy'

'Firmly a place for this work'.

the, a lot of the discussion, the working through was. To do was to do with encountering an HIV positive client. As a person and as a practitioner for the people that worked there. Uhm and that's a very very different thing. Than you know working, being aware of this client group and working with this client group. And sort of thinking about what comes up consistently. Within that work. It's a, you know, it could be two dissertations, I guess.

And that's it.

Yeah, yeah.

I think that was where initially I was just I want to do all the research (laughter). And had to like reign myself back in and go okay, I'll do this and I'll do this. So uhm.

Yeah.